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1. Background

Brief history of First Correctional Medical (FCM)–introduction

FCM was founded in 1996 by Tammy Kastre, M.D., originally under the name of Tammy Y. Kastre, M.D., P.C., specifically to meet the extraordinary health care challenges facing correctional institutions. In 1996, the company began providing correctional nurses and contract staffing for correctional facilities. It has grown into providing full-risk medical managed care to facilities throughout the United States and in Canada.

During this time, FCM has become well versed in all facets of correctional medical management. FCM's individual track record in providing these services is unmatched in the industry. Staff work in partnership with clients to ensure that quality medical services are provided in the most cost-effective manner appropriate to the medical facility, while at the same time working with the custody staff to maintain a safe and secure environment. The company has been based in Tucson, Arizona, since its inception.

The Department of Correction will receive proposals from several correctional health care companies. Why should the evaluation team select FCM to provide its correctional health services? Reasons include:

- FCM is a privately held company that is directly responsive to the needs of its clients, for this contract, the Department of Correction.
- In many states the company is certified for preference under the state's program for small, minority, or women owned business.
- The company is physician owned; thus medical care is paramount.
- The company is directed by goals of preventative medicine; correctional health care is not seen as simply a business or management service.

FCM will have no difficulty meeting the eligibility criteria outlined in the proposal process section of the request for proposals. Staff have obtained and reviewed the document, Combined Registration Application for the State of Delaware Business License and/or Withholding Agent. There will be no problems with completing the document and meeting the requirements. In addition, FCM has no relationships that may be perceived as conflicts of interest as outlined in Appendix C to the request for proposals.

Management structure

FCM's President and chief executive officer, Tammy Y. Kastre, M.D., has the authority, accountability, and responsibility for total organizational performance and leadership of FCM corporate and contract site staff. FCM has employed a team of dedicated managers and directors who handle the daily operation of each contract and report directly to Dr. Kastre. In addition, key corporate staff are closely involved in the operations of the facilities. Reporting directly to Dr. Kastre are the health services administrators of each facility as well as Kris Foti, Ph.D., vice

president mental health; Mike Johnson, director of operations; Norma Peal, Ph.D., director of development; Heeten Desai, M.D., corporate medical director; and Renee Manda, R.N., M.B.A., director of education.

The Delaware corporate office will include the required staff to coordinate services at all facilities of the Department of Correction. Full-time staff will include an office manager, director of nursing, an administrative assistant, and human resources coordinator. In addition, the Delaware medical director will spend approximately one-half time in the office performing administrative functions and the other one-half providing direct services. FCM's MIS manager and dietitian for all facilities will also coordinate with staff in the Delaware corporate office.

Current staffing

FCM employs a staff of 160. Fifteen work in the corporate office administrative area; the remaining employees work at the various facilities where FCM provides correctional health care. FCM provides health services in both prisons and jails. FCM also has experience working with juvenile offenders.

FCM's number of employees was higher in 2000 when it had over 200 staff. The number in 2001 declined due to the discontinuation of contracts with Corrections Corporation of America (CCA). CCA experienced a financial crisis that led to a dramatic corporate restructuring, including the resignation of the principal corporate medical staff. As part of its restructuring, CCA elected to discontinue its medical contracts with Correctional Medical Services, Prison Health Systems, FCM, and Stadtlanders Pharmacy. CCA placed all medical services under direct CCA control.

Current services provided, populations served, target population

Very simply, FCM provides correctional health care. As stated above, FCM provides health care services in both prisons and jails (for both adults and juveniles), the company's target populations. Although FCM has previously provided limited services, the company prefers to be responsible for comprehensive on-site and off-site services. This allows FCM to provide coordinated, cost-effective care.

Date firm was organized to provide services

FCM began providing services in 1996. The chief executive officer and president has extensive health services background, having extensive experience as an emergency department physician. Dr. Kris Foti, an officer of the corporation, also has extensive health services experience. As is discussed later, FCM will be sending a core team to provide transition and start-up services in Delaware. This team includes members with decades of health care background. Please see the résumés included as attachment 15 and discussion below to confirm the extensive experience of FCM's staff.

Correctional health care is FCM's only line of work. This allows the staff to concentrate and excel in this field. The below tables show that FCM has the background and experience to manage all components of the facilities of the Delaware Department of Correction. FCM has been responsible for providing health care services to nearly 13,500 inmates. Currently, FCM provides services to

5,000 inmates. As described above, the number of staff and inmates declined in 2001 when CCA experienced a financial and organizational crisis and rescinded its health services contracts.

Since 2001, FCM has expanded greatly its administrative services and staff to take on a project such as providing correctional health care services for the Department of Correction. Administrative staff have had the opportunity to refine policies and procedures, implement nationwide contracting where possible, negotiate new subcontracts, establish a core team of professionals for initiating new services. In fact, FCM is strategically and financially in an optimal position to take on this new service.

Evidence of ability to work cooperatively in the treatment and criminal justice areas

Probably the best evidence of FCM's ability to work cooperatively can be obtained by contacting any of the references provided in this document. Other verification is FCM's very low number of lawsuits (indicating quality of care that results from cooperative services), and an overall positive record in carrying out every contract ever awarded. Further, as the charts and discussions below indicate, FCM has successfully obtained or maintained ACA and NCCHC accreditation or compliance in its facilities, per the requirements of the request for proposals.

2. Capability

Infirmary and hospital care

Table 1 provides statistical information from FCM's current facilities for 2001 regarding the company's experience to provide services to the Department of Correction.

Table 1. FCM's capability statistics (annualized)

	Infirmary	Hospital
• Admissions per 1,000 inmates	136	7
• Inpatient days per 1,000 inmates	476	15
• Average length of inpatient stay	Varies	2.25 days
• Average length of inpatient mental health stay	3 days	* See note
• Average length of inpatient chemical dependency withdrawal	3 – 5 days	3 – 5 days
• Mental health admissions per 1,000 inmates	180	* 14
• Chemical dependency withdrawal per 1,000 inmates	50 – 75	50 – 75

* Unable to determine length of inpatient mental health stay when they are taken outside the facility because inmates frequently do not return to the facilities and thus staff do not track their stay.

Similar current and past contracts (includes all contracts

The following table provides information about all current and past similar services provided by First Correctional Medical. All contracts were successful. As requested, the table includes the target population, the number of inmates served, a brief description of the services. The table also includes the dates of service and accreditation information.

Table 2. FCM's operations and contract services

Facility Name and Location	Target Population	Beds	Dates of Service	Description of Services	Type of Accreditation
Pima County Juvenile Detention Tucson, Arizona	Juvenile detention	160	7/02 – 6/07	Full risk and full medical management	Will be NCCHC accredited
Pima County Adult Detention Center Tucson, Arizona	Adult detention	1,600	3/02– 2/07	Full risk (after initial ninety days) and full medical management	Will be NCCHC accredited
Central North Correctional Centre Penetanguishene, Ontario, Canada	Adult detention and correctional	1,152	10/01– 10/06	Full risk and full medical management	Will be ACA compliant
North Coast Correctional Treatment Facility Grafton, Ohio	Adult corrections	552	7/01– 7/03	Full risk and full medical management	ACA compliant ACA audit pending 5/02
Lake Erie Correctional Institution Conneaut, Ohio	Adult corrections	1,380	4/00– 4/05	Full risk and full medical management	ACA accredited 4/01 NCCHC compliant
Florence Correctional Center Florence, Arizona	Adult corrections	1,500	12/99– 12/00	Full medical management	ACA compliant
Cimarron Correctional Facility Cushing, Oklahoma	Adult corrections	900	8/99– 9/00	Professional medical staffing services	Non-applicable
Davis Correctional Facility Holdenville, Oklahoma	Adult corrections	900	8/99– 9/00	Professional medical staffing services	Non-applicable
Diamondback Correctional Facility Watonga, Oklahoma	Adult corrections	1,500	8/99– 9/00	Professional medical staffing services	Non-applicable
North Fork Correctional Facility Sayre, Oklahoma	Adult corrections	1,400	8/99– 9/00	Professional medical staffing services	Non-applicable
Bartlett State Jail Bartlett, Texas	Adult detention	950	8/97– 4/00	Professional staffing	ACA accredited NCCHC accredited
T. Don Hutto Corrections Center Taylor, Texas	Adult corrections	500	8/97– 4/00	Professional staffing	ACA accredited

Jesse R. Dawson State Jail Dallas, Texas	Adult detention	2,000	7/97– 8/98	Full risk and medical management	ACA compliant
Eloy Detention Center Eloy, Arizona	Adult corrections	1,500	2/96– 3/00 4/00– 9/00	Professional staffing Full medical management	ACA accredited 5/00
Central Arizona Detention Center Florence, Arizona		2,500	2/96– 10/98 10/98– 02/01	Professional staffing Full medical management	NCCHC compliant

Capacity to manage proposed services successfully

As discussed above, FCM has had an enviable opportunity during the past year to refine many of its administrative and operational functions. After carefully considering several corrections projects nationally, FCM has decided to use its experience in Delaware by submitting a proposal for services to the Department of Correction. Submitting this proposal is not a trivial decision. Staff members have investigated many opportunities during the past year and decided that based on its strategic plan, the company should move forward in two directions: services in its own geographic area and services statewide in a small state. To meet the first goal, in October, 2001, FCM submitted and was subsequently awarded the Pima County, Arizona, contract. To meet the second goal, staff considered opportunities in many states. After careful analysis, executive staff determined that they had the capacity, experience, and desire to provide services in Delaware. This is demonstrated concretely by the complete success with its current and past contracts, excellent references, and demonstrated experience of its management staff.

Corporate experience in correctional health care (number of employees, annualized payroll, years in business

Currently, FCM employees a staff of 160. Fifteen work in the corporate office administrative area; the remaining employees work at the various facilities where FCM provides correctional health care. Following is information for the most recent four years indicating the number of employees and gross revenue:

- 2002–160 employees; gross revenue $11,000,000 (projected)
- 2001–95 employees; gross revenue $4,561,813
- 2000–200 employees; gross revenue $9,700,069
- 1999–60 employees; gross revenue $4,668,190

Accreditation and related information for current facilities

Table 3 specifies the facilities that are currently accredited and non-accredited.

Table 3. FCM's accreditation information

Facility name	Type of accreditation	Dates of re-accreditation	Fines, funds lost, lost accreditation, on probation, etc.
Pima County Juvenile Detention Tucson, Arizona (contract pending 7/02)	Will be NCCHC accredited; ACA compliant	NCCHC within 24 months of contract award	None
Pima County Adult Detention Center Tucson, Arizona	Will be NCCHC accredited; ACA compliant	NCCHC within 24 months of contract award (February 2004)	None
Central North Correctional Centre Penetanguishene, Ontario, Canada	Will be ACA and NCCHC compliant	NCCHC and ACA are U.S. standards; this facility is Canadian	None
North Coast Correctional Treatment Facility Grafton, Ohio	ACA compliant ACA audit pending 5/02	ACA audit pending 5/02	None
Lake Erie Correctional Institution Conneaut, Ohio	ACA certified 4/01 NCCHC compliant	ACA received 2001	Fine for psychiatrist and psychiatric nurse vacancies July 2001 through February 2002; resolved

Subcontractors or suppliers

M.M.S. Medical Supplies
(Formerly Perigon Medical Distribution Corporation)
237 S. 23rd Street
Phoenix, AZ 85034
Laura Becko, account representative
Telephone: 520-235-2445
Fax: 520-572-4746

Secure Pharmacy
416 Mary Lindsay Polk Drive, Suite 515
Franklin, TN 37067
Joe Facchinei, account representative
Telephone: 800-833-2510 x 1531
Fax: 888-598-8053

Henry Schein
Medical Supplies
135 Duryea Road
Melville, NY 11747
Telephone: 800-851-0400

St. John's Companies
P.O. Box 51263
Los Angeles, CA 90051-5563
Scott Taylor, account representative
Telephone: 800-435-4242 x286
Fax: 888-270-6823

Briggs Corporations
7887 University Blvd.
P.O. Box 1698
Des Moines, IA 50306-1698
Telephone: 800-247-2343
Fax: 877-736-8614

Facilities on probation

No facility is currently on probation. In fact, FCM has never had one of its facilities on probation.

Copy of surveys

Attachment 1 is the accreditation document from the Lake Erie Correctional Institution. As FCM is no longer the health services provider at Eloy Detention Center, staff do not have access to the facility's document. In addition, FCM provided comprehensive medical services for three years the Bartlett State Jail in Bartlett, Texas. The chief executive officer of FCM was a key participant in obtaining NCCHC accreditation for the facility. The actual document was received shortly after the contract ended.

3. Organizational Changes

FCM has had no corporate reorganization or restructuring in its seven year history. Further, FCM will maintain its privately held status to continue the company's history of being a flexible, competitive business. The only anticipated business obligation that will coincide with the term of this contract is an amendment to the recently awarded contract with Pima County, Arizona. The contract will be amended in approximately July 2002 to include the provision of comprehensive correctional health services for the 160 juveniles housed in the county's Juvenile Detention Facility. FCM is also exploring correctional opportunities in Australia with its long time partner, Management & Training Corporation (MTC). FCM has been awarded a contract with MTC to provide correctional health care services for a 1,500 bed correctional facility in Costa Rica. The start-up will not begin immediately as MTC is in the preliminary stages of the design-build process. This will be the first privately operated correctional facility in Central America. The project has a slow,

deliberate start-up that in no way could interfere with start-up or ongoing operations for the Delaware Department of Correction.

4. Financial Status

Financial statements are included as Attachment 2. Insolvency will be avoided because of FCM's solid track record and the stability of the current contracts which carry us through 2007. FCM's extremely limited litigation record also exhibits the strong foundation upon which the company operates.

5. Legal Status

FCM has an outstanding record for risk management and medical legal liability. There are no known civil litigation or criminal charges involving FCM, its contractors, or subcontractors, pending or actual, except the following. Tammy Y. Kastre, M.D., and FCM have been or were involved in only the two legal actions discussed below. Each entry includes the name of the litigation, date filed, description of the case, and the action and outcome.

Name: Billy Chance vs. Correctional Corporation of America, Tammy Kastre, M.D., First Correctional and Training Corp., Alimadad M. Jatoi, M.D., and Correctional Physician Services; filed October 16, 2000.

Description: In 1998, inmate Billy Chance, while at the Jesse B. Dawson State Jail in Dallas, Texas, was scheduled for an outside consultation visit with an ear, nose, and throat (ENT) specialist. FCM held the medical services contract at the time the appointment was scheduled.

Action and outcome: On August 31, 1998, the contract between the State of Texas and CCA ended. Thus CCA ended all contract with subcontractors. Subsequently, Management & Training Corporation (MTC) in conjunction with Correctional Physician Services (CPS), assumed responsibility for custody and medical services, respectively. CPS did not keep a consultation appointment for Mr. Chance and subsequently Mr. Chance claimed medical negligence. This case was settled in November 2001 for under $150,000.

Name: Walter A. Bryant v. Management & Training Corporation; filed September 24, 2001

Description: Mr. Bryant is claiming medical negligence from leg nerve damage from a popliteal aneurysm that occurred while incarcerated in the Lake Erie Correctional Institution. FCM believes that the aneurysm was correctly identified and treated and his subsequent complaints are not from medical negligence but rather from the natural course of his disease.

Action and outcome: The case is currently being researched.

6. References

References

Following is information for several individuals familiar with FCM's background, qualification, and ability to implement the proposed project.

Felipe Lundin, Director
Pima County Department of Institutional Health
150 West Congress Street
Tucson, Arizona 85701
(520)740-3745

Al Murphy
Vice President Correctional Services
Management & Training Corporation
500 North Market Place Drive
P.O. Box 10
Centerville, Utah 84014
(801) 693-2600

Ron Russell
Senior Vice President Correctional Services
Management & Training Corporation
500 North Market Place Drive
P.O. Box 10
Centerville, Utah 84014
(801) 693-2600
(801) 725-6101 cellular telephone

Joanne Ryan, D.O.
Director of Medical Services
Oklahoma Department of Corrections
2901 North Classen Boulevard
Oklahoma City, Oklahoma 73106
(405) 962-6130

Mel Henry
Director of Health Services
State of Alaska Department of Corrections
4500 Diplomacy Drive, Suite 109
Anchorage, Alaska 99608
(907) 269-7444

Contact information for contracts cancelled

The only contracts cancelled during the past three years were by CCA and are listed below. In addition, CCA terminated with FCM its contracts for professional medical staffing in the four Oklahoma facilities detailed in Table 2. The reason for this cancellation, solely an internal CCA financial crisis, is detailed above. FCM completed successfully other contracts during this three year period.

Florence Correctional Center
Contact: Brenda VanBlaircom
(520) 868-9095
Provided full medical management for 1500 bed facility.

Central Arizona Detention Center
Contact: Mike Samberg
(615) 831-7088
Provided full medical management for 2500 bed facility.

D. Organizational Structure and Operations

1. Organizational Structure

Corporate chart including Delaware Department of Correction and organization chart for proposed services

Attachment 3 includes both FCM's corporate chart including Delaware Department of Correction as well as the organization chart for the proposed services.

2. General Operations

Strategic Planning Process

FCM has embraced a strategic planning process that emphasizes slow, deliberate growth with regular planning sessions coordinated by the director of development. Key participants are the president and chief executive officer, director of mental health services, director of operations, director of development, director of business management, and the health services administrators from each facility. The planning group meets annually to assess activities of the previous year and establish goals and objectives for the upcoming year. In addition, the group meets quarterly either in person or via conference call to evaluate progress for the previous quarter and realign goals and objectives for the upcoming quarter.

Developing and updating policies and procedures

FCM has established a comprehensive policies and procedures manual that encompasses all areas of health services. The director of clinical services has primary responsibility for changing and updating the manual. Ultimately, the director of operations is responsible for ensuring that all policies and procedures are consistently applied across all institutions and facilities. At a facility level, each health services administrator has ultimate responsibility for monitoring the implementation of any changes. Such implementation is conducted in close conjunction with the nurse educator who organizes, plans, and often conducts training for staff and others (such as corrections officers). The director of operations in conjunction with the health services administrators will ensure that the Delaware Department of Correction is apprised of all changes.

Although there is one master set of policies and procedures, FCM customizes the manual for each jurisdiction in which it operates. One administrative assistant has responsibility for maintaining all changes to the documents and also maintains a master forms manual (electronic and hard copies) that are integral to the policies and procedures.

Protection of confidentiality

The principle of confidentiality protects patients from disclosure of certain confidences entrusted to clinicians during a course of treatment. FCM embraces the philosophy of this principle and, in compliance with NCCHC and ACA standards, extends this to the inmates-patients and their clinicians. Some exceptions do exist such as reporting of certain alcohol and drug abuse, specific communicable diseases, and child abuse.

FCM strictly adheres to the confidentiality of all inmate records and will honor all Department of Correction policies and procedures for safeguarding the confidentiality of such data. FCM policy A-20 discusses in detail confidentiality of inmates' health records. Discussion of confidentiality is also an important part of the new employee orientation. Attachment 4 is FCM's policy A-20.

Grievances and complaints

FCM's policy addresses grievances and complaints. Staff will coordinate with the Delaware Department of Correction both at a facility level and a statewide level.

FCM follows all NCCHC and ACA standards as they relate to inmates' inquiries, writs, complaints, and grievances and will follow legal requirements for testifying in court. Further, FCM has in place an in-depth quality management program that includes risk analysis. One component of risk management is quality management that includes the analysis of grievances.

Court cases

FCM abides by the ACA standards 3-JDF-3D-08 and 3-ALDF-3E-11 in its grievance procedure. FCM believes that by instituting policies and procedures that meet ACA and NCCHC standards and by adhering to strong medical principles and administering preventive medicine, staff can minimize the number of grievances. If a grievance is filed, the health services administrator will use all available resources to validate or invalidate the nature of the complaint and will handle it immediately, as is deemed necessary by FCM's medical director, facility physicians, and health services administrator, to minimize any further problems and rectify as appropriate.

Further, FCM will follow the procedure outlined in the inmate complaint and grievance procedures section and Appendix J of this request for proposals. FCM will modify its policy and procedure to incorporate all requirements including the maintenance of monthly information on all grievances filed and actions taken. FCM will coordinate closely with staff of the Department of Corrections at all levels regarding inmate grievances. This will range from intrafacility communications to meetings of the Medical Administrative Committee and Medical Review Committee.

coordinate reporting

Attachment 5 is FCM's policy for complaint resolution.

Equal opportunity

It is FCM's policy to provide equal employment opportunity for all applicants and employees. The corporation does not unlawfully discriminate on the basis of race; color; religion; sex; national origin; ancestry; marital status; sexual orientation; age; physical or mental disability (including AIDS and HIV); request or denial of pregnancy leave or family medical leave; or past, present, or future membership in a uniformed service of the United States including status as a disabled veteran or Vietnam era veteran. FCM also makes reasonable accommodation for disabled and disabled veteran employees and for employees' religious observances and practices and meets all requirements of the Americans with Disabilities Act.

All applicants and employees are apprised of the company's equal opportunity policy at the time of hire. Ultimately the human resources manager is responsible for ensuring implementation and monitoring of all aspects of this policy.

FCM's equal opportunity is included in the employee handbook, attachment 17.

Drug free work place

FCM strictly adheres to having all facility and administrative work places drug free. FCM also participates with the contract requirements for random drug testing program with all facilities. In addition to requiring all facility staff to pass required drug screening, all administrative staff recently successfully completed full background screening, including drug screening. FCM's drug free work place policy is provided to each applicant during the hiring process. Ultimately, the human resources manager is responsible for implementing and monitoring compliance

FCM's drug free work place is included in the employee handbook, attachment 17.

Urine testing program

5/29 — Mike Johnson

FCM adheres to the urine testing program of each jurisdiction in which it operates. The director of operations and each health services administrator is responsible for fully cooperating with the requirements.

Corporate Director of Operations bilingual staff

Language and cultural compatibility

Because FCM operates in areas with a variety of cultural and language differences, it ensures that it hires staff who possess the necessary characteristics for successful communication with inmates. FCM hires bilingual staff members as much as possible in its health services facilities. However, if no staff member speaks an inmate's language, health services staff will try to find a corrections or mental health staff person who does so. For instance, in the Central North Correctional Centre, in northern Ontario, many inmates' first language is French. Therefore, several staff are bilingual English and French. As a last resort, FCM will access an interpretation service, either in the community or available by telephone for such services. Similarly, in the unusual situation of a person needing sign language communication, FCM will seek other staff in the facility to interpret. However, if necessary, FCM will use the services of community organizations that provide interpretation services.

5/29 — Will pay a higher rate for bilingual

3. Continuous Quality Improvement

Description of quality improvement program (QIP)

- Will use interpreters / Custody Staff / ATT interpreter Switch

Introduction. The purpose of the quality management program is very simply to provide a systematic means of monitoring and improving the processes within each facility. FCM's policy A-26, in compliance with ACA and NCCHC standards, describes a multi-faceted quality management and improvement program that includes: quarterly (or more frequent) meetings to include the facilities' mental and physical health practitioners, continuous quality improvement audits at least quarterly, peer review audits conducted at least quarterly, and unannounced corporate audits conducted by the corporate staff including the corporate mental health director. Besides this policy, FCM has developed a comprehensive quality management program manual that is available for review by the Department of Correction.

This manual's sections include:

- Quality Management Program and QM Organization Chart
- Quality Improvement
- Quality Improvement–Calendar and Indicators
- Quality Improvement–Plan, Do, Check, Act (PDCA) Workbook
- Risk Management
- Risk Management–Monthly Monitors
- Infection Control Overview (FCM has an entire infection control manual)
- Inmate Education–Tuberculosis Lesson Plan Sample
- Medical Staff Credentialing
- Peer Review
- Case Management
- Utilization Review Tool

Quality management is the all-encompassing philosophy that extends throughout the organization's management infrastructure, policies, and compliance. Under the umbrella of the quality management committee, the quality management program consists of five functional areas: quality improvement, risk management, infection control, medical staff, and utilization management. There is a constant and consistent flow of information between the functional areas. In many circumstances, duties and reporting structure may extend from one functional area to another.

A key component of quality management is a systematic, organization-wide approach for improving the overall quality of care as well as compliance to the standard of care. The quality assurance nurse (or an RN with this responsibility) in each facility manages this functional area. The duties include reporting on monthly indicators, directing focus studies, and working collaboratively with the director of clinical services and health services administrator to monitor PDCA projects. PDCA is a recognized quality management tool that was showcased at the NCCHC conference in 2000 in St, Louis.

Quality assurance is the result of a comprehensive quality management program. It encompasses the functional areas, compliance, management, infection control, peer review, etc.

Peer review. The medical director facilitates peer review by overseeing the duties of the medical staff to ensure that appropriate health care is accessible and provided to the inmate population. The medical director is responsible for peer review activities regarding care provided to inmates according to FCM's polices and procedures and current industry standards for clinical practice. The medical director works in collaboration with FCM's chief executive officer on medical protocols, educational programs, and utilization review activities. The medical director reviews a pre-determined number of cases every quarter. It is the responsibility of the medical director to review each case with the specific provider and develop a corrective action plan to assure improved performance. The medical director is responsible for providing written reports to FCM's chief executive officer for review. Summary reports will be available to the Department of Corrections and to all required entities.

Compliance. Each of FCM's contracts calls for a myriad of compliance components. To meet the requirements and to continue monitor for compliance, the staff use their quarterly and focus indicators that are based on ACA, NCCHC, OSHA, JCAHO, and all other mandates such as state, federal, and local requirements. These indicators allow the state to complete a concurrent, up-to-date review of activities. It is based on sound and prudent medical industry standards.

The following resources can be used to assess a facility's level of performance relative to the dimensions of performance:

- Contract stipulations
- Regulatory guidelines
- Log books and comparative data bases
- Statistical and manufacture quality control guidelines
- Stratified trend and pattern analysis
- Clinical protocols
- Sentinel events
- Peer review
- Utilization review data
- Case management studies

On an ongoing basis, assessment is performed to interpret the data collected to provide information about the facility and the level of performance related to the dimensions of performance. Outcome assessment may include the following:

- The degree of compliance to outcome objectives
- The stability of an existing process
- The nature of variation in a process
- The need for improvement or additional education

FCM is committed to continuous quality improvement and performance as a method to systematically assess and improve clinical and operational efficiency. All plans to establish a new process or service or plans to change substantively existing processes or services will be evaluated prior to implementation using the PDCA process.

Risk management. The regular quality management committee reports on the activities of the risk management program. These may include:

- Analysis of trends identified through variance reports
- Summary and status of mortality and morbidity reviews
- Closed case liability and analysis review
- Trending of grievance reports

The risk management program ensures that adherence to the program will promote a safe environment for all inmates, visitors, and employees, ensuring adequate precautions against potential injury. A sound risk management plan reduces potential loss exposures for the

Department of Correction and FCM. Such exposures can constitute potential loss of financial assets through liability judgments or casualty losses to its physical plant and property, human losses through death or injury, and less tangible losses to the department's image and reputation. Therefore, there is joint responsibility for the identification and elimination of potential risks.

Risk management is a functional unit that is intricately involved in the processes, goals, and activities of many committees and programs in the health care setting. Although there is not a direct involvement in the daily function of these committee or areas, there are key elements in each committee that carry a certain amount of risk exposure.

Risk analysis may include analysis of a single event such as:

- Assessment of applicable records, reports, and logs
- Interviews of medical and custody experts, such as those in pharmacy, radiology, clinical lab, and infection control, as well as correctional officers and other staff of the Department of Correction.
- Review of applicable log and data entry books
- Review of applicable policies and procedures
- Review of applicable contracts
- Assessment of applicable equipment and supplies

Methods to monitor quality of care and improve services

To monitor quality of care and improve services, staff must :

- Assess the stability of current performance relevant to contract compliance, functions, processes, and outcome, by utilizing quarterly indicators
- Identify through means such as focus studies areas that may require staff education
- Identify changes that will lead to improvements by using process improvement methodologies such PDCA program discussed below.

Examples of programs. One highly successful problem solving program that FCM embraces is the PDCA program. New and seasoned staff alike frequently offer suggestions for improving a process. Some suggestions are valuable but others may impact other processes and activities. To evaluate possible alternatives, staff must follow the prescribed steps of the PDCA program. The first step is for the staff person to write a comprehensive analysis of the issue and submit the analysis along with recommendations for change to the corporate director of operations and the chief executive officer. If the project is approved, the staff then implements the program which is run concurrently with the existing program. A comparison is made between the two programs in order to determine if a recommendation for implementing the change is appropriate.

Staff have successfully implemented quality improvement changes using this process. For instance in one facility, inmates with HIV were medically required to have double portions of protein. However, the food preparation staff received the order to provide the inmates double portions of all food. A staff person prepared a PDCA, recommending that the protein only be doubled. After successful completion of the process, the practice was adopted and the procedures

changed. Another PDCA intervention changed the system for providing inmates information and education about care for chronic conditions. This resulted in a systematic program for providing consistent, accurate health care information. This fits well with FCM's approach of preventive, cost-effective health services.

Quality improvement (QI) calendar. One key to a successful quality program is establishment and strict adherence to a quality improvement calendar. The yearly calendar details the quarterly indicators and the threshold for compliance. The QI plan ensures that the quality improvement activities occur year round. Data on each indicator are gathered quarterly. The threshold for each indicator is established on a risk compliance factor. The sample size relates to the associated risk volume in each category and the likelihood that the specific aspect of care is problem prone. If the aggregate threshold compliance is not met, the quality manager analyzes the criteria responses and establishes an action plan to commence as soon as possible. The indicators are monitored within thirty days of implementation. Each facility measures its performance with respect to the needs, expectations, and contract stipulations.

Each indicator reflects a related NCCHC or ACA standard, if applicable. These indicators include:

- Inmates' rights and organizational ethics
- Assessment of inmates during intake
- Planning and providing care
- Medication usage
- Nutritional care
- Segregation assessment
- Chronic care clinic
- Observation care and medical management
- Outside referrals
- Emergency care
- Special needs
- Mental health management
- Ancillary services such as radiology, laboratory, vision care, medical records, dental care

Focus studies. Another monitoring tool is the use of focus studies to monitor specific areas of concern to identify process problems or educational needs. A focus study monitors a low volume function that carries a high-risk outcome if the process is not followed correctly. Examples include medication records and keep on person (KOP) signatures and effectiveness outcomes of resuscitative interventions.

A focus study may also monitor a high volume function with an associated high-risk outcome if the process is not followed correctly. For example a focus study involving mental health services may include mental health medication compliance or the use of restraints.

A focus study assessment is performed when any of the following occurs:

- The performance within a facility varies significantly from recognized standards
- A single event, level, or pattern that significantly varies from the expected threshold emerges

- There is a critical area of concern
- A significant adverse drug reaction occurs
- There is a significant medication error
- A sentinel event takes place

Reporting is the cornerstone of the quality management program. Results from quality indications, risk management summaries, and focus studies are submitted monthly through quality management committee meetings. Other vital reports are the monthly statistical reports and the hospitalization reports from the health services administrator that are vital to the utilization review function. Similarly, the quarterly provider peer review reports that are sent to the corporate office are vital to the quality management process.

All FCM employees will receive a basic quality management introduction as part of their new hire orientation. The introduction includes training on the performance improvement philosophies and the vision, mission, and values of FCM and the contracting agents. The quality management department will provide training on relevant tools and techniques. All employees will take an active role in quality management activities. The health services administrator will directly oversee this and the FCM nurse educator will indirectly administer the quality management department in each facility.

Quality management in-service education will be provided at each facility in the medical unit in order to guide and motivate the quality management practice of others in the organization. By conducting staff orientation and periodic in-service programs, staff can be trained to practice more effective loss control techniques and embrace risk management procedures.

Examples of quality management educational programs include:

- Infection control to include the bloodborne pathogen exposure plan and the tuberculosis exposure control plan
- General orientation including the facility pre-service correctional-focused orientation
- Issues of informed consent
- Documentation
- Loss prevention and trending
- Handling of variance reports
- Correctional health care standards

All quality management reports, summaries, and meeting minutes are maintained in the quality management office in locked files. All quality management reports, peer review reports, occurrence reports, risk management reports, and quality management meeting minutes are considered confidential. To that end quality management committee meetings are not for public review. Further, any reference to inmates by names or numbers or to employees' names are omitted in referenced quality management educational in-service sessions.

Monitoring by physicians include chart reviews, provider peer review by the medical director or designee, and investigation of inmates' complaints, to name a few. If an inmate's grievance involves an issue of a worker's scope of practice, the health services administrator will initially

review the grievance. The complaint and supporting documentation will then be forwarded to the FCM medical director or designee for action.

FCM has an entire set of performance monitoring tools that will enable the Department of Correction to determine compliance with key elements of the company's performance at the facilities. These will be compiled regularly and available for review. FCM has established quarterly and monthly calendars that spell out the activities that are to be monitored.

Ensuring consistency in quality and level of care statewide

FCM evaluates regularly its quality management program at the corporate level. For Delaware, FCM will continually evaluate its programs and care to ensure consistence in quality and level of care services. During the evaluation, priorities are established for the ensuing period and indicators are revised as necessary. Input in the evaluation process is required from all levels of program participation.

The medical director will perform regular on-site monitoring of all health services through various means including direct supervision, chart review, investigation of inmates' complaints, and review of all quality management meeting minutes, records, and reviews. In addition, as discussed above, the medical director, with review by the clinical director, will be responsible for providing written reports to all required entities.

Of course any program is only as successful as its staff. To ensure top quality staff, FCM rigorously investigates and educates its staff. This begins before the time of hire when FCM's human resources department thoroughly checks each professional's background including licensure. The overall process helps establish a practitioner's background and ensure that the person's current competencies meet industry standards. This includes:

- Current licensure
- Current competencies
- Current certifications such as CPR
- Relevant education, training, or experience
- Ability to perform requested privileges

Education is part of a person's background as well as ongoing process. FCM embraces continuing education by providing education payment and time away from work for such activities.

Consistency in quality and level of health care services statewide

The primary mechanism of FCM that will be implemented consistently in every one of its facilities is the quality program outlined in its comprehensive quality management program manual. The company is small enough to allow personal involvement at each facility by the director of operations as well as the chief executive officer who is also a practicing emergency department physician. This personal oversight combined with a comprehensive, understandable program of quality management will ensure that every inmate in every facility receives the same quality of care.

4. Utilization Review Program

Concurrent review is the process of obtaining necessary information from providers and facilities concerning the care being provided to the inmates. FCM will carry out such review on-site regularly. Concurrent review determines the appropriate level of service consistent with the inmates' needs, identification of case management opportunities, and discharge planning. In general, components are:

- Verification of authorization for admission and projected discharge dates for inpatient stays
- Determination of further medical needs including moves to a higher acuity hospital, non-acute care facility, or skilled nursing facility
- Referral to the FCM medical director for review when the stay no longer meets coverage criteria
- Coordination of discharge planning activities – for both medical and custody care.
- Identification of any quality of care issues
- Referral for additional review

Percentage of cases reviewed

Overall, FCM reviews cases as follows:

- All inmate deaths for determination of appropriateness of care
- Five charts monthly for medical peer review for determination of appropriateness of care
- All emergency transfers to emergency departments regardless of mode of transportation (facility van, ambulance, air unit) for appropriateness of care
- Complete chart audit for any hospitalization over $15,000 for financial review and appropriateness of care.
- All hospitalized inmates for day-to-day case management updates

Note that all emergency transfers are reviewed and discussed at quality committee meetings. If there is a trend noted, a further investigation as to appropriateness or process will be completed.

Medical provider involvement

The appropriate medical provider and medical director are involved in all mortality and medical peer review activities. In addition, the medical provider will be a member of the quality management committee. See attachment 6, FCM's morbidity review form.

Emergency transfers are reported to the quality management committee. If members note a trend, a further investigation of appropriateness or process will be completed.

Outside provider requests reviewed and approved for medical/surgery, mental health, and dental services

The following is the most current information for the number of outside provider requests and denials for the Lake Erie Correctional Institution and North Coast Correctional Treatment Facility. Note that the information for the North Coast Correctional Treatment Facility is six months of operation as services started there July 1, 2001.

Table 4. Outside provider requests and approvals

Service	Lake Erie Correctional Institution (January 1, 2001 through December 31, 2001)	North Coast Correctional Treatment Facility (July 1, 2001 through December 31, 2001)
Medical/surgery requests	474	151
Approved medical requests	436	140
Dental requests	32	3
Approved medical requests	32	3
Mental health requests*	14	4
Approved mental health requests*	14	4

* Information for inpatient mental health services that would not be provided by on-site staff, such as re-assigned to a residential treatment unit

Coding system of diagnosis and procedures

FCM issues an authorization code for all outbound off-site visits. The billing specialist tracks invoices by facility and by date of service. Diagnoses and procedures are tracked by ICD – 9 and CPT codes.

Review criteria and procedures

- Medical necessity for proposed treatment, including chemical dependency withdrawal

The referring physician, dentist, podiatrist, optometrist, or other specialist must write the order for the specialty consultation in the inmate's medical record. The medical director must approve all clinical referrals that are initiated by other clinicians, including mental health practitioners. A clear direction for the time frame for implementation of the consult must be designated by the referring physician. The order must specify the following referral status–either routine (to be scheduled or placed on the institutions pending list as appointments become available) or as soon as possible (to be scheduled at the next specialty clinic).

Medical director approval

As discussed in FCM policy A-3, screening of inmates for medical detoxification services will be conducted by the medical staff during the intake assessment process. Such detoxification includes withdrawal from alcohol, opiates, hypnotics, stimulants, and sedative hypnotic drugs. Usually detoxification can be conducted under medical supervision at the admitting facility for the majority of inmates. Rarely, an inmate with a poly substance abuse history combined with other complicating factors may be transferred for inpatient detoxification.

- Medical necessity for admission to off-site facility

The medical provider (staff or specialist) will provide as much care as possible to resolve the medical problem either diagnostically or therapeutically before referring for consultation. Referrals for off-site services will be approved only when the clinical findings indicate a condition that cannot be managed at the facility level.

- Medical necessity for admission to the infirmary

Inmates with the following conditions may be placed in an infirmary:

- Dizziness
- Post seizure activity
- Objective weakness
- Control of diabetes
- Observation of head trauma (no loss of consciousness)
- Multiple electrocardiogram tracing per physician orders
- Heat exposure
- Allergic reactions
- Convalescent care

The nursing staff will initiate a separate medical record for each inmate admitted to the infirmary. Inmates in the infirmary will be checked by nursing staff at least every eight hours and observations appropriately documented in clinic notes.

If an inmate is identified as requiring daily skilled nursing care beyond the resources available in the facility, the physician will be notified within twenty-four hours and appropriate transfer will be initiated under suitable security provisions to a facility where such care is available.

- Necessity for continued stay

To determine the necessity for continued stay, the on-site provider will view and reassess inmates every twenty-four hours or more frequently, as needed.

- Mental health care (inpatient and outpatient)

The medical director must approve all clinical referrals that are initiated by other clinicians, including mental health practitioners.

- Necessity for surgical procedures (inpatient and outpatient)

The medical director must approve all clinical referrals that are initiated by other clinicians, including referrals for inpatient and outpatient surgical procedures.

- Case management

One objective of case management is to track and monitor episodic care events. Following are examples of episodic events tracked and monitored through case management:

- Special needs, temporary or permanent
- Inmate grievances
- Hospitalization, outpatient or inpatient
- Off-site specialty clinics
- On-site specialty clinics
- Utilization review

- Outpatient services

The medical director must approve all clinical referrals that are initiated by other clinicians, including referrals for outpatient procedures performed off-site.

5. Record Auditing Program

As a part of the quality management program, the integrity of medical records is audited quarterly. If staff note a trend or an indicator falls below an established threshold, the appropriate staff will develop, execute, and evaluate an action plan.

Verification of discharges

It is the responsibility of the health services administrator or the shift supervisor to telephone the hospitals daily for a clinical progress update on any hospitalized inmate. The health services administrator or designee will confirm the status report with the on-site provider. If there are issues or concerns about the treatment plan, the provider will confer with the off-site physician and or the FCM medical director. All inmates discharged from a hospital will be placed in the medical observation unit for a final evaluation before returning to their assigned housing unit. Return from hospital

Impact of pre-admission and continued stay review (including savings calculated)

The health care literature abounds with information regarding the impact of utilization review in decreasing costs. In fact, a cornerstone of managed care is utilization management. FCM has very few of its inmates admitted to off-site facilities. For those who are admitted, FCM coordinates daily with staff of the facility for status updates. In addition, FCM's contracts with hospitals outline that services provided by such a facility are only to be provided as specifically prior authorized. For instance, if an inmate is admitted for an appendectomy, FCM will approve payment for that procedure but would not pay for an elective tubal ligation that was not prior authorized. For all of

these reasons, FCM has never directly tracked money saved by this process. However, FCM is willing to collaborate with the Department of Correction to begin collecting such information as needed.

Transmission of data to medical records system

The health services administrator or designee will complete a progress note in the inmate's medical record with the daily update from the hospital personnel. Any further action will also be noted into the progress note.

Elements collected

The health services administrator or designee will include in the daily report the follow information:

- Location of inmate such as ICU, obstetrics, medical/surgery
- Current vital signs and any notable trending to include unit, respirations, blood pressure, temperature, and pulse
- Out of range lab results and pending labs
- Results of pending radiology procedures
- IV fluids including IVPB medications
- Oral medications
- Pain level assessment and medication given
- Physical assessment (nursing)
- Completed and pending consultations
- Physician update plan of care and or treatment plan
- Nutritional status

Sample utilization review documents

Attachment 7 includes documents used for utilization review. It includes the twenty-four hour health services administrator's report, the monthly health services report, the nutritional assessment monthly report, and the non-formulary item request form.

6. Cost Containment Programs

Overview of cost containment and cost savings programs

FCM's track record in providing contracted correctional health services is unmatched in the industry. FCM's staff work in partnership with clients to ensure that quality medical services are provided in the most cost-effective manner appropriate to the medical needs, while at the same time working with the facility's staff to maintain a safe and secure environment. FCM's services for the Department of Correction will follow these standards.

The following list includes FCM's current and proposed cost containment and cost savings programs recommendations. The list is divided into administrative services and health care services.

Cost containment through administrative services include:

- Pricing based on the entire six year initial period requiring both FCM and the Department of Correction to both assume some risk (instead of a year to year contract as requested in a formal question to the Department of Correction)
- Pricing on a flat cost instead of a "cost plus" basis (an actual disincentive to cost containment as there is no incentive to properly curtail and manage services) with no cap
- Operating the Delaware facilities from one central office rather than with three regional managers as is currently done
- Provision of one person as the central point of contact to the Department of Correction to handle and coordinate all concerns
- Pre-authorization of all outside referrals for service
- The "just in time" system of inventory (discussed in the equipment section of the proposal)
- Negotiated contracts with providers with the most advantageous fees possible
- Aggressive collection of inmates' co-pays and third party liability such as private insurance, as discussed below

One additional key administrative cost containment that FCM recommends is a fresh approach in performance assurance. FCM will agree to authorize the Department of Correction to hold $500,000 (instead of the $250,000 retainer outlined in the request for proposals) from its first month's payment and throughout the term of the contract. For the Department of Correction, this will result in decreased costs for payment of performance bond and increased revenue from interest earned annually on $500,000. Besides the monetary components, this arrangement would still provide the Department of Correction a means to both assure that FCM performs in accordance with the contract and its proposal but would also decrease risk associated with non-compliance.

Cost containment through health care services include:

- Performing tuberculosis testing, in accordance with NCCHC *Standards for Health Services in Prisons* that "all new adult and juvenile admissions . . . be screened for TB" (for new admissions only if documentation of a transferred inmate verifies previous testing)
- Rotating specialty staff throughout the nine facilities–to include the quality assurance registered nurses
- Inclusion of a dietician for menu planning as well as diet education to inmates
- Inclusion of one registered nurse to serve as the nurse educator for all facilities to include monthly in-service sessions (see attachment 8, FCM's 2002 in-service calendar); the nurse educator also to provide limited education to inmates with long term chronic conditions (nurse educator provided through FCM's G & A budget–not a direct staff cost to the Department of Correction)
- Use of outcome driven nursing protocols for inmate sick call and as needed for emergencies
- Workable quality management program that establishes accountability through a quality improvement and risk management program
- Providing health services as a continuum of care, much as it is seen under a managed care model

Pharmacy/ MLS

- Incorporating health education and prevention into every aspect of health care services (a proven cost savings mechanism over time)
- Provision of services on-site whenever possible (routine and specialty clinics as well as ancillary services)
- Use of physician extenders and other ancillary providers
- An aggressive utilization management program that decreases inmates' length of stay as inpatients (discussed in other sections of this proposal)
- Use of a formulary as well as careful review of nonformulary items
- Program to reduce appropriately the number of psychotropic and similar drugs

The cornerstone of FCM's cost containment program is providing health care to inmates using a managed care model. To that end, health care is seen as a continuum of care, including care provided at receiving screening, in chronic care clinics, off-site, in specialty clinics, and throughout discharge planning to ensure continuity of care.

For services to the Department of Correction, FCM will meet Delaware law and generally accepted community standards of health care. FCM will also conform to all federal and state law. But FCM will not simply meet minimal requirements. Instead, staff will take positive steps to institute comprehensive polices and procedures and will ensure that everyone follows them. Every action and service within the medical units will meet FCM policies and procedures as well as ACA and NCCHC standards.

In addition FCM will introduce an enhanced preventive medical program. The professional health care literature abounds with empirical data that verify the economic and health values of preventive health care. The ultimate goal of instituting such stringent directives and programs will be not only to improve inmates' health outcomes but also to decrease risk and litigation.

Integral of both preventative and acute medical services is education. FCM health services staff will provide health education programs to inmates with specific conditions. Those with chronic conditions will receive directed education about their particular disease process. These conditions include diabetes, hypertension, heart disease, infectious disease, neurological problems, cardiovascular problems, and pulmonary disease. Additional educational sessions and materials will be available at sick call, from free pamphlets, and from aftercare instruction sheets. Topics of these will include diabetes, diabetic foot care, wound care, exercise, living with heart disease, reducing hypertension, infection control, sexually transmitted diseases, smoking cessation, and stress and anger management (FCM policy A-11).

FCM is aware of the challenges in obtaining qualified staff in correctional facilities. As discussed later in this proposal, FCM has an aggressive recruitment plan to find such staff. To the extent possible, FCM uses physician extenders and other ancillary staff such as pharmacy technicians, nursing assistants, and medical records clerks to provide the services they are certified to perform. All providers practice within the scope of their licenses.

PA, NP

To the extent possible, all services will be provided on-site at each of the facilities. It is FCM's policy to bring specialists to the facilities for services. Some of these are more traditional to correctional facilities and include providers of optometry care, dental services, and radiology. But

FCM goes an additional step to arrange clinics for services such as ophthalmology, orthopedics, obstetric and gynecology care, geriatric needs, and cardiology. Off-site clinics are based on the specific needs of each institution's inmates.

Economies of scale and conditions for change

FCM recognizes that inmate population varies based on factors such as legislative changes, economic factors, area population variations, and so forth. If fluctuations are moderate, FCM would not revise fees. However, if the population changes substantially, FCM would expect to work closely with the Department of Correction to adjust the fee. FCM would expect to receive an increased fee if a complete new service is required or a new facility (or section) is added to its responsibility. FCM would anticipate that such increases would be unusual. If the inmate population simply increases substantially within an existing facility, FCM would discuss adding only specific staff (such as nurses to meet NCCHC requirements). The basic infrastructure of staff and equipment would remain unchanged.

Discounted provider arrangements

FCM negotiates aggressively with providers for the most advantageous contracts for services. Whenever possible, staff use the Medicaid fee schedule as the base for hospital and professional fees. In addition, FCM contracts with on-site providers to provide services to a minimal number of inmates during a session.

Inmate co-pay program implementation

FCM firmly supports inmate co-pay programs. Such programs are important in proper triaging of care, reducing frivolous requests, and encouraging inmates to take responsibility for their health care to the extent possible. FCM views the provision of correctional health services as a unique and distinct specialty. Safety and security are the primary goals in the correctional environment. To meet these goals from a health care perspective requires an understanding of how to deliver health care within the secure environment while simultaneously dealing with a population that can be manipulative and a constant drain on medical resources. Meeting these goals requires dedicated personnel who understand the correctional health care environment and the inmate population. It is critical to be able to distinguish between those inmates truly in need of medical services and those only trying to gain attention or participate in some other form of maladaptive behavior.

FCM will work cooperatively with the Department of Correction and follow the policies and procedures outlined in Appendix G of the request for proposals that establish standards for the application of inmate co-pays for health care services. FCM has extensive experience with such programs in other facilities.

Obtaining inmate insurance reimbursement

As part of the receiving screening process that each inmate receives, FCM will investigate the existence of health insurance or other third party liability. This is especially vital for unsentenced

inmates whose coverage may remain active at this stage of their incarceration. FCM's medical records staff and other administrative workers will follow-up aggressively to collect such fees.

Risk management plan including critical elements and mortality review

Probably the most effective way to decrease risk is to adhere closely to NCCHC and, as appropriate, ACA standards in all areas of operations. One vital area discussed in-depth in the NCCHC manuals and throughout this document is the need for a quality management program that includes risk analysis.

FCM's policy A-26, in compliance with ACA and NCCHC standards, describes a multi-faceted quality management program that includes: quarterly (or more frequent) meetings to include the facilities' mental and physical health practitioners, continuous quality improvement audits at least quarterly, peer review audits conducted at least quarterly, and unannounced corporate audits conducted by the corporate staff including the mental health department. Besides this policy, FCM has developed a comprehensive quality management program manual that is available for review by the Department of Correction. This manual's sections include:

- Quality Management Program and QM Organization Chart
- Quality Improvement
- Quality Improvement Calendar and Indicators
- Quality Improvement—Plan, Do, Compare, Act (PDCA) Workbook
- Risk Management
- Risk Management Monthly Monitors
- Infection Control
- Inmate Education—Tuberculosis Lesson Plan
- Medical Staff
- Peer Review
- Case Management
- Utilization Review Tool

Quality management in-service education will be provided at each facility in the medical unit in order to guide and motivate the quality management practice of others in the organization. By conducting staff orientation and periodic in-service programs, staff can be trained to practice more effective loss control techniques and utilize risk management procedures.

FCM's mortality review procedures and critical elements

The medical director for each facility is responsible for morbidity and mortality review. The health services administrator is responsible for compiling monthly reports of all morbidity and mortality reviews.

FCM follows NCCHC standards for actions in the event of an inmate's death. The death of an inmate, preventable or unavoidable, will be investigated by the health services administrator in collaboration with staff with responsibility for risk management as well as with appointed custody staff.

A mortality review is initiated within thirty days of the inmate's death. However, from FCM's perspective the review begins immediately with all involved immediately reviewing and documenting all actions taken by the health services and corrections staff and all other involved individuals.

The review is conducted in person or via teleconference between facility staff and corporate staff. The committee (including the FCM chief executive officer, health services administrator, systems administrator, medical director, mental health director, appropriate facility staff, and other relevant health services staff) will meet within ten working days. All must have access to the complete medical and mental health records, medication records, emergency department records, hospital summaries, incident statements generated by the event, and the autopsy report including the toxicology screening.

The ultimate goals of a mortality review are to develop or improve an existing educational lesson and to identify any aspect of the medical care delivery system or the partnership of health care and custody that can be improved. Another of the outcomes of a mortality review is to determine if there was a pattern of symptoms that might have resulted in earlier diagnosis and intervention. The review also examines events immediately surrounding a death to determine if appropriate interventions were undertaken. Each death is compared with other inmates' deaths to determine if it was part of an emerging pattern.

Similar reviews are conducted for other critical events such as emergency services provided to inmates or others at any facility. FCM's policy A-7 fully describes this process. It includes an evaluation of the nursing assessment and triage, appropriateness of referral, timeliness of all elements, appropriateness of the mode of transport, and the quality of care rendered.

7. Insurance

FCM's insurance will meet the insurance guidelines from the request for proposals. FCM currently maintains general liability coverage of $1,000,000 per occurrence and $3,000,000 aggregate with excess liability of $2,000,000 per occurrence and $2,000,000 aggregate combined to provide coverage of $3,000,000 per occurrence and $5,000,000 aggregate. FCM believes that the limits required in the request for proposals meets industry standards. Unlike the bidder that requested via the formal question process to negotiate lower rates, FCM believes that appropriate levels of insurance benefits all involved–the Department of Correction, the vendor, subcontractors, inmates, and any others who may seek damages. Therefore, FCM has arranged to increase the limits to meet the requirements of the request for proposals if selected as the vendor for the Department of Correction.

E. Health Care Services

1. Routine Services

Although each facility of the Department of Correction operates semi-autonomously, they are also part of a larger system of correctional facilities. With that overarching concept always paramount, FCM will plan its health services separately for each facility but will take advantage of the benefits of a larger system. For instance, FCM will:

- Be able to negotiate more favorable contracts because of the large number of patients providers could serve
- Distribute staff among facilities depending on needs at any given time
- Hire key staff (for example physician, psychiatrist, dentists, and QA nurse) to provide services at more than one facility
- Refine its current policies and procedures the encompass the entire array of facilities and inmates
- Participate actively in system-wide committees and groups (such as the county-wide Medical Administrative Committee and Medical Review Committee) as well as "ad hoc" groups

However, FCM is aware that each facility is unique in terms of its culture, inmates, services, staff, etc., and that services will need to be customized to fit the specific needs of each facility. For example, staff will certainly perform medication distribution procedures at all facilities, but the process will vary. At the Sussex Work Release Center, most medication will be distributed via the medication boxes. But at in the maximum security sections of Delaware Correctional Center, all medications will be distributed individually through the cell fronts.

For each facility and its component units, FCM will establish specific procedures for delivery of every service. It would be presumptuous to outline in this document how every service will be provided based on three days of visits and summary written material. Immediately upon contract award, FCM will began an in-depth analysis of the current system of providing services. Within the first few weeks of operation the transition team will have analyzed the existing system and made a plan for modifying, adding, or deleting various components.

FCM is experienced in doing this. For instance staff are now nearing the end of the ninety day transition period. Immediately upon contract award notification for the Pima County Adult Detention Center, FCM began planning revision of services. This facility consists of three fairly autonomous facilities on one campus and a small facility, Ajo Jail, over 125 miles away. Even before starting services on March 1, 2002, FCM executive staff visited the staff at the Ajo Jail and spent a day meeting with jail staff, community service providers (the local health department staff, local clinic staff, and emergency medical services providers) to plan improved services. Ultimately, many services will be delivered via telemedicine. Because that will take several months to implement, FCM established an interim health services plan for the jail that includes FCM's medical staff at the main facility, community providers, and corrections staff. FCM will do similar analyses for each of the facilities of the Department of Correction.

FCM ensures that care in its facilities is comparable to care provided in the community through various mechanisms. First, it adheres stringently to NCCHC standards. Second, it coordinates closely with community providers and actually uses a large number of community service providers at its facilities.

Perhaps most importantly, the company's chief executive officer and president, Tammy Kastre, M.D., is a practicing, active physician who is personally involved in each facility that the company operates. She is active in all medical components ranging from establishing medical protocols to actually working in each of the facilities. Dr. Kastre is a firm believer in providing quality care. This is confirmed by the extremely low number of law suits ever filed and the low number of inmate grievances in FCM's facilities.

Staffing and use of infirmaries in each institution and facility

FCM's staffing plan for each facility is detailed in later sections of this proposal. Because factors vary greatly in each of the facilities operated by the Department of Correction, so will the staffing. Generally the criteria for determining staffing levels are the size of the facility, types of services required (medical, nursing, mental health), scope (outpatient, infirmary) of services delivered, the needs of the inmate population, and type of facility. Also, special consideration is given to the number of inmates in segregated housing. For instance, Delaware Correctional Center provides nearly all services for those in the maximum security cell front, including medication distribution. In addition these inmates must be escorted individually to the medical room on each unit. These factors combined will require higher staffing ratios than at other facilities where inmates walk independently to a pill window or the medical services area.

Specific to staffing of infirmaries, FCM will use each facility's infirmary units to their fullest extent consistent with NCCHC standards. These call for a medical provider on-call twenty-four hours per day, supervision twenty-four hours per day by a registered nurse present at the facility, on-site staff as needed, availability of a manual of nursing procedures (many references will be available as outlined below), maintenance of the required inpatient health records with encounters documented in inmates' medical records, admission by an appropriate medical provider, and regular rounds by medical staff at required intervals. The infirmary staff for facilities with infirmaries will be responsible for on-site emergency care at all times of every day. FCM will ensure that twenty-four hour emergency care is available to every facility and that an on-call licensed health care provider is available and ready to respond within thirty minutes to any site that does not have an infirmary.

FCM avoids using nursing agencies or pools whenever possible by creating its own cadre of available nurses for ongoing part-time work or on-call part-time work. The human resources manager and nurse educator ensure that all are specifically trained in correctional health care and are to FCM policies and procedures. In addition as the facilities of the Department of Correction are in relative close proximity, FCM will establish processes for reassigning staff among facilities if necessary.

FCM fully intends to minimize off-site transports of inmates for any health care services. This includes inpatient services. To accomplish this, FCM provides infirmary services to the highest level possible while still providing the appropriate level of care. If needed, FCM will increase staffing to accommodate infirmary staffing if it will decrease off-site admissions. Not only are off-

site visits expensive for the medical provider, but also for the Department of Correction that must incur high security expenses. Further, transporting inmates off-site jeopardizes public safety by increasing the risk of inmate escapes.

As much as possible, FCM will strive to bring services to inmates, even if the service is housed at another facility operated by the Department of Correction. For instance, even transporting inmates to another facility for x-ray services can still provide a security risk. Therefore, as much as possible, FCM will use mobile services and arrange on-site clinics.

FCM policy A-23 discusses medical observation beds on-site. Such medical housing is intended to be used as transient housing for the delivery of medical care to inmates who do not require inpatient hospitalization or inpatient skilled nursing. At each facility, the physician on-call after hours or the health care provider on-site will be responsible for assigning all medical housing. Guidelines for placing inmates in an on-site medical observation bed include: dizziness, status post seizure activity, objective weakness, control of diabetes, observation of head trauma when no loss of consciousness occurred, observation for drug reactions, multiple electrocardiogram tracings per physician orders, heat exposure, allergic reactions, and convalescent care. Inmates placed in medical observation beds will be checked by nursing staff at least every eight hours. All observations and care, including vital sign monitoring, will be documented and a progress note written by one of the health care providers for every inmate at least every twenty-four hours.

Health assessments

The ideal system for providing initial health assessments (sometimes referred to as receiving screenings or intakes) for inmates in a pre-trial is a two step program. However, as the Department of Correction has both types of inmates in its facilities, it may be more expeditious to provide a single step process. Regardless of the process, FCM will meet the required standard of completing a receiving screening within two hours of inmate arrival for all facilities.

FCM will also ensure, per the required standards, that transfer screenings are completed within twelve hours of the arrival for all transfers into prison facilities. If a single step is employed, the process will be completed within two hours at all facilities. The first component of the two step process is a cursory screening for all inmates to ensure that they are medically appropriate for incarceration. The second phase is a more in-depth, hands-on medical receiving screening. Both phases incorporate not only medical components but also screenings for serious mental health, alcohol, or other substance abuse concerns.

All health screening will be conducted by licensed health care personnel within twelve hours of inmates' arrival. Inmates will not be assigned to the general population until the screening form is completed. All findings will be recorded on the screening form approved by the health services administrator.

As appropriate, FCM recommends that the first phase be verbal screening only and be conducted within minutes of inmates' arrival. It will be carried out by a health care professional who will talk with each detainee to determine the appropriateness of incarceration at the facility. The main purpose of this initial screening will be to detect those who pose a health or safety threat to themselves or others or those who may require immediate health care.

Those deemed medically appropriate for incarceration will move on to the second phase of the receiving screening process when cleared by custody staff. During this phase, the health care worker will complete a receiving screening that will include areas such as:

- The inmates' medical, dental, and mental health history
- Current medications and special health requirements
- Past history of health conditions
- Alcohol and drug abuse history and problems
- Significant mental health concerns
- Dietary requirements

The receiving screening process will also include the health care worker's observation of the inmate's general appearance and behavior as well as physical deformities and evidence of abuse or trauma. If the receiving screening worker has concerns about a serious mental health issue, staff will contact a mental health worker to consult immediately with the inmate. FCM will meet the required standard of assuring pregnancy testing for all female inmates upon initial intake at all facilities.

For any inmate with a positive PPD or exhibiting the signs and symptoms of possible tuberculosis, staff will isolate the person immediately and contact the appropriate medical provider for orders. Inmates who will remain at the facility for an extended time (fourteen days per CDC standards) will receive a PPD test to determine their tuberculosis status. FCM does not want to administer the PPD test to an inmate who will not be at the facility to have the test read. Transferred inmates with verifiable tuberculosis testing in the required timeframe will not receive another PPD test unless other factors indicate its value. If the Department of Correction so requires, FCM will administer the PPD test to all inmates during the screening assessment process. FCM will meet the required standard of tuberculosis screening and reading within forty-eight to seventy-two hours of test for all facilities.

The health care worker will determine the medical disposition of the inmate, explain to the inmate the processes for obtaining health care at the facility, and verify the inmate's next of kin information. At this point, FCM staff will enter relevant inmate medical information into the company's proprietary Inmate Medical Manager electronic system (and the Delaware Automated Correction Systems as appropriate). Starting the tracking at this point will assure comprehensive continuity of care including timely referral to on-site chronic care clinics, referral for communicable infectious disease follow-up as needed, and mental health referrals.

A health appraisal will be completed for each inmate within seven days of admission to a prison facility and fourteen days to a jail facility, as required to meet both NCCHC and ACA guidelines, unless the inmate has been transferred from another institution and has medical records reflecting a health appraisal completed within the previous ninety days. Tuberculosis prophylaxis will be initiated if indicated in accordance with the Center for Disease Control and Prevention's 1996 jail standards.

Routine services

The following paragraphs discuss the routine services specified in the request for proposals. FCM will provide them as well as all other services needed to provide comprehensive health and medical services to all inmates of the Department of Correction. Others not specifically mentioned that FCM will provide include:

- Rehabilitation services such as physical and occupational therapy
- Ophthalmology services and clinics
- Orthopedic services and clinics as indicated
- Detoxification in conjunction with the substance abuse program staff
- Segregation assessment–prior to placement
- Ecoparasites prevention, identification, and treatment services
- Chronic care disease specific education and treatment not limited to only the common conditions such as diabetes and asthma
- First aid kits recommendations (contents and location) and assistance maintaining
- Extensive security staff education program
- Automated external defibrillator (AED) education for security staff
- Food services worker pre-assignment medical exams

The following paragraphs present a synopsis of the routine services specifically mentioned in the request for proposals.

- Intake

Receiving screens (or intakes) are outlined in the health assessment section above.

- Eye exams

FCM intends to provide vision services on-site either as routine or special clinics. Health services staff will explore inmates' vision and other eye problems during the receiving screening and other health assessments. FCM has been successful in finding community optometrists with portable equipment (often such providers also visit patients in skilled nursing facilities). FCM follows Medicare guidelines regarding those who meet criteria for glasses and orders glasses through Orco Supplies, a vision supply company. Orco supplies glasses within seven days of receiving the order. FCM understands the obligation for furnishing, repairing, and replacing prostheses.

- Hearing exams

Health services staff will explore inmates' hearing problems during the receiving screening and other health assessments. FCM will provide formal hearing assessments for those inmates noted to require an evaluation. As much as possible, FCM will arrange for the providers to come to the facilities. If this is not possible, FCM will arrange for off-site services by an appropriate specialist such as an audiologist. FCM will provide needed hearing aids.

- Dietary services

ACA standards describe the requirements for providing special diets as prescribed by medical personnel. NCCHC standards require the provision of therapeutic (special) medical and dental diets that are prepared from specially developed menus in accordance with an approved diet manual and served according to the orders of the treating physician or dentist, or as directed by the responsible physician. FCM will abide by all standards in the provision of therapeutic diets, including those of the *Manual of Clinical Dietetics* and the *Manual of the American Dietetic Association.* Ensuring that inmates receive therapeutic diets will require close coordination among health services staff (including FCM's dietician) and communication with both corrections and food services staff. Providing proper dietary services is an integral part of FCM's health education and health promotion services.

- Hemo and peritoneal dialysis

FCM will contract with a local dialysis provider to provide these services at the two facilities that have dialysis rooms. In its cost proposal, FCM assumed that the five dialysis beds that will be operational at the time of contract start-up will be fully equipped and that the Department of Correction will be responsible for handling the water and treatment systems. FCM will provide supplies and staff but expects the pharmacy contractor to provide the medications (including Epogen, Calcijex, Zemplar, Heparin, Vanco, Ampho B, Cipro, and quinine tablets).

To the extent possible, FCM will work with the Department of Correction to transfer inmates to one of these facilities. If that is not possible because of the inmate's classification or other factors, FCM will work with custody staff to bring the inmate to the appropriate facility. As a last resort will FCM arrange transportation to off-site facilities. However, FCM recognizes that off-site, regularly scheduled appointments are a serious security risk. Therefore, FCM will work closely with dialysis providers to minimize such risks.

- Boot camp physical exams

Health care staff will evaluate the health of inmates in the Sussex Correctional Institution's boot camp prior to their participation in this rigorous program and at other times as required by the policies of the Department of Correction.

- Medical care for injuries

Most injuries can be successfully treated during regular clinics or on an unscheduled basis. Of course inmates, visitors, or staff with emergency or life threatening injuries will be transported to an appropriate facility either by emergency medical services providers or corrections staff vehicles. Health services staff will evaluate individuals with possible emergency conditions, provide first aid or emergency care, and coordinate for proper transport.

Far more frequently, health services staff will have the necessary qualifications and experience to treat inmates' injuries. Providers, including physicians and physician extenders, will be able to perform wound care including suturing, evaluation of joint and bone injuries, burn care, etc.

- Prosthetics and convalescent aids

FCM policy, in compliance with ACA and NCCHC standards, provides that medical and dental prostheses and orthodontic devices will be provided when the health of the inmate would otherwise be adversely affected as determined by the responsible physician or dentist. These include eye glasses, hearing aids, crutches, and wheelchairs.

Sick call procedures

Daily sick call will be conducted at least five days per week at all facilities (in compliance with the request for proposals) and will be accessible to all inmates regardless of their security status. To facilitate and improve the efficiency of the sick call procedure, the triage system will be utilized. The sick call request, usually referred to as a "kite," will be screened by qualified nursing personnel using the triage process. Inmates will be scheduled for further evaluation by a physician, dentist, or mental health provider, as indicated. Nurse sick call will be conducted at least five but usually seven days per week at most facilities and will be accessible to all inmates regardless of their security status (FCM policy C-4). FCM encourages, supports, and requires patient confidentiality. As one part of this, medical staff will collect sick call requests at least every twenty-four hours from locked mail boxes located in each housing area. Note that staff will address serious medical conditions immediately. FCM will work with staff of the Department of Correction during the transition period to set up the optimal system for obtaining sick call requests at each facility.

FCM's Inmate Medical Manager electronic request system provides not only consistent, timely medical care but also allows for complete tracking and auditing of every inmate's request. The system includes a triage component that ensures that every kite is answered within twenty-four hours. Inmates with urgent needs will receive services the same day; all other requests will be met within five days.

Because FCM emphasizes preventive care and quick resolution of health problems, sick call will be held daily. In addition to providing sick call for routine problems, a registered nurse will make regular rounds of housing units to inquire of any health concerns and immediately address any serious problems. This is especially vital for inmates who are confined to their cells most of every day (such as those in maximum security or segregation units).

Tuberculosis treating procedures and protocols

Tuberculosis is an extremely serious problem in correctional facilities. It impacts not only inmates, staff, and visitors, but also presents a community-wide public health risk for inmates who are in work release programs, are transported to community providers, or are released from a facility.

FCM has developed and maintains a several hundred page *Infection Control Manual.* Major divisions include: infection control program, infection control committee, bloodborne pathogen exposure control plan, tuberculosis exposure control plan, tuberculosis skin test and interpretation, employee tuberculosis testing, standard precautions, isolation procedures, hand washing, medical supply decontamination, disposal of sharps and syringes, medical waste management, personal protective equipment, spill kits, and reportable diseases. The manual is updated regularly. FCM's

policy manual addresses infectious disease education. All of these documents are in compliance with ACA and NCCHC standards. FCM will coordinate with the Department of Correction in any revisions to its policies, procedures, and manuals as they relate to communicable diseases

Inmates with positive PPDs or exhibiting the signs and symptoms of possible tuberculosis will be isolated immediately. The identifying health services worker will contact the appropriate medical provider for orders. FCM will administer PPD tests for inmates as outlined in the health assessment section above.

Providing tuberculosis treatment and prevention services goes far beyond simply providing medical care to infected inmates. FCM's comprehensive tuberculosis program encompasses coordination with local health officials (for testing, reporting, etc.), training health services and corrections staff about tuberculosis, and providing education to inmates to emphasize prevention and health promotion as well as treatment.

Services for inmates with special medical conditions

- Chronic care

FCM's policy C-2 details its process for assessing and managing inmates in chronic and convalescent care clinics. This policy, in compliance with NCCHC standards, will be modified and implemented for all facilities operated by the Department of Correction.

FCM will provide disease-specific education to inmates with chronic medical conditions together with appropriate medical care for their diseases. These conditions include diabetes, hypertension, heart disease, infectious disease, neurological problems, cardiovascular problems, and pulmonary disease. Most inmates will receive such services in chronic care clinics that FCM will make available to them no less than every ninety days. The objectives of such clinics are:

- Education of patients about the disease process to promote self care and good health practices
- Maintenance of individual treatment plans that include the type and frequency of laboratory and other tests to detect or correct biochemical and metabolic abnormalities
- Provision of periodic routine visits to decrease the rate of progression of the disease and to minimize its complications, and to provide inmates with disease monitoring and education regarding medications, exercise, and diet

As part of its health education, chronic care services, and other clinics and programs, FCM maintains a comprehensive array of materials for inmates to read. In addition, FCM maintains at each facility up-to-date professional materials such as appropriate journals and reference guides. The following is a list of some of the reference guides available to providers:

- *Clinical Orthopaedics*
- *Emergency Medicine, A Comprehensive Study Guide*
- *Harrison's Principles of Internal Medicine, 14th Edition*
- *Physician Desk Reference*

- *Quick Look Drug Book*
- *Grant's Atlas of Anatomy*
- *Mosby's Correctional Medicine*

- Convalescent care

FCM provides convalescent care almost exclusively on-site at facilities that have infirmary beds. FCM policy A-23 discusses the use of such beds and their appropriate use for a number of conditions including convalescent care. Such medical housing is intended to be used as transient housing for the delivery of medical care to inmates who do not require inpatient hospitalization or inpatient skilled nursing. The physician on-call after hours or the health care provider on-site will be responsible for assigning all medical housing. Inmates placed in medical observation beds will be checked by nursing staff at least every eight hours. All observations and care, including vital sign monitoring, will be documented and a progress note written by one of the health care providers for every inmate at least every twenty-four hours.

- Specialty clinics (including telemedicine)

Whenever possible, services will be brought to the inmates via contracted providers or during regular and special clinics. FCM's basic philosophy regarding this is that every possible service that can be provided at a facility should be provided there. FCM has adopted this philosophy for several reasons.

- It ensures that inmates receive services as quickly as possible.
- It provides better continuity of care, especially if the care is rendered by the same providers each week (or other time frame). This fits well with FCM's model of providing managed care that emphasizes preventive care.
- It decreases the expenses associated with transporting inmates from the facilities. These expenses include security and possibly medical staff members' time, vehicle costs, and paperwork preparation time, to name a few.
- Perhaps most importantly, providing services on-site decreases public risk and increases public safety that could result from an escape or accident during a transport.

However, FCM realizes that, at times, taking an inmate to an outside consultation may be necessary. Staff will minimize such outside transports and work closely with the Department of Correction to arrange transports at the times most convenient for them.

FCM's standard on-site services include comprehensive medical, dental, and mental health services. Also, routine ophthalmology, obstetrics, orthopedics, HIV and AIDS, rehabilitation services including physical therapy, and others will be provided at all possible and appropriate facilities. Additional on-site clinics could include general surgery, podiatry, dermatology, and prenatal care.

Determining which services will be provided as regular clinics, special clinics, or off-site services will depend on an array of factors such as the number of inmates needing the service, the custody level of the inmate, space limitations, and sometimes the sex of the inmates.

For example, as warranted by the number of pregnant inmates requiring prenatal care, FCM will either provide a regular prenatal clinic or individualized prenatal services on-site at facilities where females are housed for routine pregnancies. FCM will work closely with appropriate medical professionals for prenatal care. Staff will also coordinate with the local health departments, as appropriate, for consultation regarding health education services, including sexually translated diseases. As appropriate, FCM will directly provide pregnancy counseling to inmates desiring information or will obtain the services of staff from appropriate community agencies.

Specialty clinics can also be provided using telemedicine services. Although telemedicine has great potential in the correctional setting, for the Department of Correction, FCM recommends limited use of telemedicine, at least initially, during the term of the contract. Telemedicine is very viable in correctional settings that are remote from providers or in localities where specialists are not available for services. This will seldom be the case for FCM because the facilities are not remote and because FCM will arrange for specialists who will come to the facility to provide services.

Telemedicine is a valuable tool, but it is not a panacea. Challenges include:

- The expense of purchasing new equipment and upgrading existing equipment as well as
- Purchasing expensive scopes and related instruments,
- Scheduling complexities
- Training health care workers at the local and remote sites
- Relative newness of the technology that often leads to technological problems

For these and other reasons, FCM proposes that if the Department of Correction decides to implement a telemedicine program, it limits services initially to simple areas such as basic dermatology, orthopedic, and psychiatric consultations.

If the Department of Correction decides to move forward with telemedicine, FCM will be eager to work cooperatively with the staff. FCM's director of development has experience working in the development and implementation of a successful telemedicine program for WellPoint's Blue Cross of California Medicaid program. Since June 1999 the program has provided over 1,800 clinical consultations and over 900 non-clinical ones. Non-clinical uses encompass medical continuation activities and teleconferences. Of the 1,800 clinical consultations, 42 percent were for dermatology, 14 percent for psychiatry, 8 percent for endocrinology, 5 percent for neurology, and 4 percent for pediatrics.

- Mental health

Mental health services are detailed below in the mental health services section of this proposal.

- Hospice

NCCHC standards indicate that "terminally ill inmates include those with a life expectancy of less than one year due to illness. They may require special health services to provide comfort, relief

from pain, and special counseling and support in anticipation of death." FCM will meet these requirements for hospice care. ✓ Hospice

For terminally ill inmates who are released into the community, the key to positive outcomes is continuity of care that includes coordination with community health care, social services, and spiritual providers as well as family members and friends. FCM has extensive policies, procedures, and programs to ensure such coordination and will ensure that terminally ill inmates receive proper post-release coordination for their medical conditions. ? at the facilities?

- Geriatric services

According to NCCHC standards, the frail or elderly inmates include those who suffer from conditions that impair their ability to function to the extent that they require assistance in activities of daily living such as dressing, eating, moving, and using the toilet. For such inmates, FCM will establish and execute special needs treatment plans. FCM will prepare an individualized treatment plan. That will include instructions about diet, exercise, adaptation to the correctional environment, medication, the type and frequency of diagnostic testing, the frequency of follow-up for medical evaluation, and adjustment of treatment modalities.

Typically the plan will be multidisciplinary and based on an assessment of the patient's needs. It will include a statement of short and long term goals as well as the methods for pursuing the goals. It will also include needed supportive and rehabilitative services (such as physical therapy, counseling, and self help groups) that the team deems to be appropriate.

Ancillary and diagnostic services

- Laboratory

FCM has a national contract with Sonora Quest Laboratory to provide certified specimen results in a timely fashion. Sonora Quest Laboratory will provide each facility with a centrifuge, a dedicated printer for result reporting, and disposable supplies. Sonora Quest has a toll free, twenty-four hour help line available to its contractors. Per protocol, an FCM medical provider will date and sign off on every lab report in a timely fashion, generally within seventy-two hours. Any critical abnormal lab result received after hours will be called to the medical provider on-call for immediate attention. Any abnormal lab results will be reviewed and an entry will be made in the progress notes indicating the appropriate treatment plan. Treatment or intervention will be initiated in a timely and medically approved manner.

- X-ray

FCM will provide radiology services on-site to the extent possible and will have regularly scheduled technicians at the facilities who will also be on-call for after hours requirements. FCM staff will use the existing radiology equipment that is on-site. Immediately upon notification of contract award and during the transition period, FCM will carefully evaluate the radiology services available and their quality. Staff will also explore the current procedures for providing these services at other sites (transporting inmates to other facilities or community providers). FCM has been successful in

contracting for mobile radiology services as well as purchasing reconditioned equipment. All of the options will be explored and a radiology plan finalized for every site.

- EKG

In most instances licensed practical nurses (or registered nurses for sites without licensed practical nurses) routinely perform EKGs and maintain an EKG logbook. EKG equipment is relatively inexpensive and can be transferred to sites that seldom require EKGs. Of course a person exhibiting signs and symptoms of a possible myocardial infarction will be handled as a medical emergency.

- Mammogram and ultra sound services for women

need age range

FCM will ensure that appropriate incarcerated women receive mammograms. A position statement of the NCCHC indicates that mammograms, and other procedures for women, should be based on guidelines established by professional groups such as the American Cancer Society and the American College of Obstetricians an Gynecologists, and take into account age and risk factors of the female correctional population. As nearly all female inmates of the Department of Correction are housed at the Baylor Women's Correctional Institution, FCM will establish mammogram services with a local provider. FCM will make similar arrangements for women in need of ultra sound services.

Women specific treatment and education

Providing health services to incarcerated women creates special concerns and issues not only for custody staff but also for health services staff. According to a position statement of the NCCHC, incarcerated women utilize health care services much more than men. Some of this may be physiological (such as the complexity of the female reproduction system, sexually transmitted diseases, and pregnancies.) But much is caused in all or in part by emotional or mental health concerns. These include alcohol and drug abuse, depression, stress, history of sexual abuse, and psychiatric problems.

To handle the special health concerns of incarcerated women, FCM will follow the guidelines of the NCCHC in such areas as pregnancy counseling and services, prenatal care, and family services. Further FCM will ensure that its intake and health assessments include such components as histories on menstrual cycles, pregnancies, gynecological problems, and nutritional intake. The intake exam will include a breast exam, sexual history, past medical history, pelvic exam, Pap smear, and baseline mammogram (based on age or other factors). An additional vital component that FCM will provide is appropriate services to detect sexually transmitted diseases including gonorrhea, syphilis, and chlamydia. Care to females will also include appropriate HIV and AIDS services.

Health education program (including content and implementation)

FCM will increase health education and health promotion programs. From information gathered at the brief facility tours, current health promotion and education programs are limited. Health

education is not simply a trendy catch phrase. The provision of comprehensive health education and promotion improves inmates' health status, reduces the number of chronic and acute illnesses and injuries, and overall reduces monetary expenses.

Education

FCM provides health education services in classes, on tapes, in groups, or during one-on-one instruction. Topics include personal hygiene, fitness, nutrition, preventative dental education, smoking cessation, self-examination for cancer, sexually transmitted diseases, HIV infection and AIDS, prenatal care, and stress management.

FCM will also provide, in conjunction with the substance abuse contractor as appropriate, on-site comprehensive and appropriate educational and health promotion programs. These may include Alcoholics Anonymous, Narcotics Anonymous, AlAnon, job skills, recreational therapy, personal hygiene, communicable disease clinics, disease prevention, and specific health education. In addition, FCM recognizes the importance of hiring multi-cultural and multi-lingual staff to provide health education services to inmates with varied cultural backgrounds

FCM health services staff will provide health education programs to inmates with specific conditions. Those with chronic conditions will receive directed education about their particular disease process. These conditions include diabetes, hypertension, heart disease, infectious disease, neurological problems, cardiovascular problems, and pulmonary disease. Additional educational sessions and materials will be available at sick call, from free pamphlets, and from aftercare instruction sheets. Topics of these will include diabetes, diabetic foot care, wound care, exercise, living with heart disease, reducing hypertension, infection control, sexually transmitted diseases, smoking cessation, and stress and anger management (FCM policy A-11).

Inmates who have a communicable disease or who may be at risk will receive proper medical treatment as well as educational services. Health education and consultation will be conducted in conjunction with local health departments and other community groups. In addition, inmates will have access to information, in non-medical terminology, and educational material on infectious diseases

FCM will also ensure that health services and custody staff have health education. FCM offers a comprehensive training program for custody staff. It can be tailored to meet the specific needs of the staff. This can be presented as a pre-service training for correctional staff and also be provided at regular intervals over time.

Triage procedures

Triage is a continuous part of most activities in correctional health care units. It is used extensively during initial health assessments (intakes), in sorting the daily sick call requests, for mental health services, during emergencies, and in day-to-day operations of clinics.

Initial health assessments. The triage process used during the initial health assessment is described above.

Daily sick call requests. Daily sick call will be conducted at least five and usually seven days per week and will be accessible to all inmates regardless of their security status. To facilitate the

efficiency of the sick call procedure, the triage system will be utilized. The sick call request, usually referred to as a "kite," will be screened by qualified nursing personnel using the triage process. The inmate will be scheduled for further evaluation by a physician, dentist, or mental health provider, as indicated. This daily sick call process is detailed in the sick call procedures section of section E1 above.

Mental Health Services. To the extent possible, FCM will have a mental health provider available at facilities. For sites with few inmates, FCM will hire nurses with psychiatric backgrounds or train the existing nurses to evaluate and triage inmates with possible mental health problems. The psychiatric nurse's primary duties include triage and assessment (in coordination with the physician and psychiatrist on-call or on-site) for all crisis interventions and medical emergencies. The mental health provider will also triage non-emergency mental health care ensuring that inmates with serious (life threatening or possible suicidal) problems are seen immediately and treated properly and that others are provided services in accordance with the severity of their mental health conditions. In most instances, inmates will remain at their assigned sites and units. However, when medically indicated, FCM will work closely with custody staff in transferring inmates with serious mental health conditions to other units or facilities.

During emergencies. Other than in life and death situations, all emergency after-hours inmate evaluations will be reviewed urgently with a physician on-call allowing joint triage by the doctor and nurse to determine the need for emergency transport off-site or provide care with the physician's guidance, as indicated. FCM intends to contract with area hospitals for emergency services. However, the number of emergency department visits will likely decrease when FCM implements its stringent triage system. FCM's goal is to provide inmates with treatment at the correct level in the correct setting. FCM's policy also mandates a retrospective review of all emergency department visits to evaluate the nursing assessment and triage of the emergency department referral. Such retrospective review will enhance staff education and lead to continued improvement in appropriate transportation of inmates for emergency services.

Medication distribution and procedures

FCM will customize the distribution of medications at each unit of each facility. Following is a discussion of FCM's pharmaceutical policy, the plan for establishing facility-specific procedures for distributing medications, FCM's overall philosophy of medication distribution, recommended packaging, training of medical staff, and involuntary administration of psychotropic medications,

FCM's pharmaceutical policy. FCM policy A-24 details all areas of pharmaceuticals including distribution. It discusses many components of distribution including training of staff in medication administration, security matters, accountability, recording, etc. The policy also discusses the keep on person program (KOP) and pill call, inmates who do not pick up medications, obtaining a resupply of medications, over-the-counter medications, crushing of medications, and medications for inmates leaving a facility (released or transferred). In addition it details management to meet inmates' needs, adherence to state and federal regulations, and minimization of the use of non-formulary drugs. Attachment 9 is FCM's policy A-24 that discusses pharmaceuticals.

Plan for establishing facility-specific procedures for distributing medications. FCM embraces systems that minimize as much as possible the amount of individual distribution of medications.

FCM has extensive, successful experience in setting up KOP programs in several facilities and will implement as much KOP and lock box distribution systems as possible. FCM will institute an adjunct to the current system used for the medication lock boxes, a self-maintained medication administration reports (MARs) that inmates will maintain but nurses will check regularly for compliance and completeness.

For each facility and its component units, FCM will establish specific procedures for delivery of medications. Immediately upon notification of contract award, FCM will began an in-depth review of the existing system for distributing medications. The review will include the distribution of both over-the-counter and prescription medications. Within the first few weeks the transition team will have analyzed the existing systems and made a plan, including a time line, for revising the systems.

FCM's overall philosophy of medication distribution. Part of FCM's basic philosophy of correctional health care is that security measures always are paramount to health services. With this in mind, staff will closely coordinate and communicate with custody staff in determining which inmates, sites, and facilities are appropriate for which type of medication distribution.

Some factors that will be integrated are:

- Several types of medications are specifically excluded from the KOP program, including anti-psychotics, antidepressants, controlled substances, muscle relaxants
- No drugs will be distributed via KOP or in locked boxes that could be used as contraband
- Inmates in maximum security units will have their medications distributed cell front as direct observed unit dose.
- To the extent possible, inmates will receive their medications, other than KOP or in lock boxes, in pill lines

FCM will abide by the requirement in the request for proposals that "at all facilities identified as jail facilities, it is the responsibility of the vendor to review and verify medications brought in from the street." FCM has developed a standard operating procedure that will include verifying the prescription and ensuring via contract through the Arizona Pharmacy Drug Index that the medication is indeed as indicated. If FCM is not able to meet these criteria, the medications will be placed in a tamper-proof container and placed with the inmates' belongings. FCM would like to discuss this procedure with the Department of Correction. Currently, except in very unusual circumstances, FCM does not accept inmates' medications but has procedures in place to obtain medication immediately from the pharmacy vendor. FCM strongly believes that using this method is a far more appropriate medical procedure.

Recommended packaging. For all medications, FCM recommends the use of blister or similar packaging of pills and capsules. This provides for increased security of the medications, decreases errors in administration, and is compatible with the KOP program. However, for some medications (those distributed via direct observation), bulk packaging may be acceptable.

Training of medical staff. All personnel who administer medications will receive training and supervision concerning facility policy and procedure relative to medication administration.

Registered nurses have primary responsibility for ensuring that medications are administered safely and that inmates understand the medication.

Involuntary administration of psychotropic medications. Psychotropic medications will be administered involuntarily to inmates only when specific conditions exist and, except in emergencies, after a due process procedure. In emergency situations, medication may be administered when, in the judgment of a physician or psychiatrist, an inmate is suffering from a mental disorder and, as a result or that disorder, presents an imminent likelihood of serious harm to self or others. In some cases, non-emergency involuntary medication may be approved, after a hearing in accordance with set procedures if an inmate is found to be suffering from a mental disorder and as a result of the disorder is gravely disabled or presents a likelihood of serious harm. FCM's policy describes procedures and actions required for forced psychotropic medication.

Treatment and discharge planning

- Overview

Treatment and discharge planning are all part of the entire continuum of care and continuity of care that inmates receive. Some of the components of continuity of care include documentation of all patient contacts, transfer of inmates' health records, providing copies (sealed for confidentiality) of health records for off-site medical care, and referral for designated infectious diseases (such as tuberculosis).

Treatment and continuity of care will begin during the intake process. This process will include initiation of treatment plans as appropriate. Starting the tracking at this point assures comprehensive continuity of care including timely referral to on-site chronic care clinics, referral for communicable infectious disease follow-up as needed, and mental health appointments.

Indeed continuity of care extends from the initial time an inmates meets a health care worker through receipt of services such as sick call, intake, chronic care clinics, off-site care, emergency care, and through discharge planning and transfer to outside services or another correctional facility.

- Sharing of information

Information acquired in a health professional-patient relationship is considered confidential. The active medical record will be maintained separately from the individual's confinement record. FCM strictly adheres to the confidentiality of all inmate records and will honor all the Department of Correction's policies and procedures for safeguarding the confidentiality of such data.

- Updating and monitoring treatment plans

Nearly all health care providers at the health services units will be actively involved in initiating, executing, and updating treatment plans. For instance psychiatric nurses and other mental health staff are part of a treatment group that work together in all aspects of treatment plans for mental

health patients. Similarly, nurses work closely with medical providers in documenting and reviewing treatment plans for lab, x-ray, and consultation reports.

Special needs inmates will all have individualized treatment plans. Activities related to such inmates are handled by the special needs committee that reports to the quality management program. Special needs inmates include those with significant medical and emotional illnesses or disabilities. For such inmates, staff will develop a written individual program of evaluation, treatment, and follow-up. The determination of special needs treatment plans will begin during the intake process when staff will identify limits of housing, work, and programs. Mental health personnel will develop plans for inmates with special mental health needs. If special needs inmates are transferred, FCM staff will notify the destination facility staff of environmental or program modifications needed. They will likewise coordinate with the designated facility staff for services for inmates whose needs cannot be accommodated at the facility as well as those who are severely disturbed or mentally retarded.

2. Emergency Services

Description of services

FCM policy A-7 discusses emergency medical care including on-site emergency first aid and crisis intervention, emergency evacuation of an inmate from a facility, the use of an emergency medical vehicle, use of appropriate health facilities, emergency on-call providers, and security procedures during an emergency medical incident. Policy A-7, Emergency Medical Care, is included as Attachment 10.

As discussed below, FCM will initiate discussions with appropriate emergency medical services providers to ensure the provision of emergency medical services for all inmates who require emergency transports via basic or advanced life support services. However, with the plan for comprehensive services on-site described throughout this proposal, off-site transports will be highly unusual. FCM's basic philosophy regarding the location of providing services is that every possible service that can be provided at a facility should be provided on-site.

When an inmate has a potential life threatening medical emergency, a registered nurse or other medical services provider on-site will assess and triage the inmate and communicate with the facility's medical director or on-call physician. That person will indicate the type of transportation required and authorize the transport. To the extent possible, inmates will be transported to contracted hospital but they may be transported to the closest hospital if the inmate's condition warrants.

FCM will work cooperatively with custody staff in establish facility-specific procedures for summoning an emergency medical services (EMS) providers. FCM's experience indicates that it is appropriate to notify the duty officer who will initiate an EMS response. Notification first of security staff will allow them to act appropriately to allow the ambulance to enter the facility. FCM also works with custody staff to train hospital staff in appropriate correctional medical techniques. Topics include not allowing inmates to make telephone calls, not discussing upcoming appointments with inmates, and not discussing the inmate's medical condition wih the inmate.

very proactive

Health services staff will also provide EMS services to staff of the Department of Correction and FCM as well as visitors.

Use of automated electronic defibrillators (AEDs)

AED's

During the site visits, participants were advised that many facilities received AEDs from special grant funds from tobacco settlements. However, from statements of some staff, it appears that there has been limited training in their use. FCM will first ensure that its own staff are all trained in the proper use of the equipment and updated annually. Similarly, FCM will work with the warden of each facility to determine training of appropriate custody staff. Part of the training sessions will be ensuring that all staff members know where the equipment is located.

Good

Sharing patient information

FCM policy A-14 discusses informed consent and refusal of treatment. The policy states that inmates are afforded the same rights to informed consent, bodily integrity, and right to refuse treatment, examination, and medical procedures as is the standard in the community. The procedure discusses the need for inmates to sign consent forms in various circumstances.

However, a portion of the procedure discusses emergency situations, stating that the informed consent requirement will be waived for an emergency clinical situation that requires immediate medical or psychiatric intervention to prevent serious harm to the inmate or others. When the physician proceeds without obtaining informed consent, the provider must exercise sound medical judgment.

Similarly, NCCHC standards indicate that "correctional staff may be advised of an inmate's health status when the health and safety of the inmate, other inmates, and correctional staff may be at risk." FCM will follow the NCCHC standards, relevant state laws, and the company's policies and procedures related to sharing information.

Ambulance transportation for off-site services

FCM establishes contracts or letters of agreement for EMS providers, both basic life support and advanced life support, in the communities where the company provides services. Immediately upon notification of contract award, staff will initiate discussions with such providers. Communities vary in their provision of EMS. In some, volunteer fire or ambulance services provide services. In others, the municipality provides the services. Some ambulance services are privately operated. FCM will determine appropriate arrangements for EMS for each facility and execute contracts. Only in extremely unusual circumstances will air ambulance services be summoned.

3. Mental Health Services

Overview of services

Incarcerated populations have historically contained a greater number of individuals with a high prevalence of psychiatric disorders, drug and alcohol addiction, and complicated neuropathology. In addition, the very fact of incarceration can create and intensify mental health problems. FCM is

aware that suicide is a leading cause of death among pretrial detainees and sentenced offenders. Individuals with undetected or untreated mental illness suffer disproportionately in the jail or prison setting, often being subject to higher rates of disciplinary segregation, physical restraint, and ostracism from their fellow inmates (mostly because of their pathology-determined behavior).

The cornerstones of FCM's delivery of mental health services include:

- Effective crisis intervention and management of acute episodes, including immediate hospitalization of the obviously psychotic and suicidal
- Suicide prevention
- Relief of presenting symptoms and the prevention of further deteriorations
- Elective therapy and preventive treatment
- Intensive custody and medical staff education

S. Rachlin M.D. in the *Mount Sinai Journal of Medicine* recognized that the most critical individuals in the rehabilitation process are the staff who are in daily contact with the offenders in their day-to-day activities. Dr. Rachlin believed the expertise of psychiatrists and psychologists can be best utilized in the training and assistance to the primary correctional staff. FCM's approach to mental health service, identification, and intervention is based on consultation with the primary correctional staff that is centered on individual care. FCM's service approach maximizes the benefits of the mental health services provided for offenders.

FCM is a strong supporter of comprehensive training for corrections staff regarding mental health services. Topics include:

- Recognition of signs and symptoms of mental and emotional disorders prevalent in the inmate population
- Recognition of signs of chemical dependence and the symptoms of drug and alcohol intoxication and withdrawal
- Recognition of adverse reactions to psychotropic medication
- Recognition of signs of developmental disability, especially mental retardation
- Recognition of potential mental health emergencies and instruction in appropriate action in crisis situations
- Identification of medical problems of inmates housed in mental health units and proper referral for care
- Suicide prevention
- Instruction in the procedures for referring an inmate to the mental health services department of immediate evaluation
- Staff first aid and CPR training

Mental health and psychiatric assessments

Overview. FCM will provide individualized treatment programs that are tailored to meet the special needs of the offender. Inmates may be referred by medical staff on the basis of intake screening, staff referral, or self referral. FCM's mental health services will include evaluation and assessment and may include short-term therapy presented in individual or group formats.

The treatment program will also include medication for appropriate inmates. In all instances, psychotropic medication will be prescribed only by a psychiatrist in accordance with generally accepted pharmacological principles and contemporary national standards. Any patient placed on psychotropic medication will have biochemical monitoring where indicated and evaluation of efficacy in all cases. All inmates will be required to sign a consent form documenting the inmate's understanding of the risks and benefits associated with the particular medication. Psychotropic medication will be dispensed only when clinically indicated and only as one element of the treatment plan. All psychotropic medications will be administered as direct observed therapy. All inmates on such medication will be monitored by the mental health staff for compliance and counseled appropriately if medications are not taken. Every inmate on psychotropic medication will be evaluated at least every two weeks to four weeks.

Initial screening. The initial screening is an important inquiry and observation process designed to ensure that newly assigned inmates, who could possibly pose a threat to their own or others health or safety, are admitted to the general population only after an appropriate level of medical intervention. Following is the process that will be implemented to ensure that each newly assigned inmate receives a thorough preliminary health screening conducted by qualified health professionals upon the inmate's arrival at a facility

The initial screening will be performed by medical or licensed mental health personnel who are qualified by training and experience to make nursing assessments of actual or potential mental health problems. The screening process will include a review of the inmate's medical file or health summary transfer form, if available, and a inquiry. Staff will document on the FCM mental health intake form of the following:

- Current and past physical and mental illnesses and health problems, including chronic conditions, past suicide or self-injury attempts
- Alcohol and drug abuse history (methods and types, as well as date and time of last use), and problems related to stoppage
- Past history of hospitalizations and treatment
- Documentation of social and historical factors related to depression and suicidal tendencies
- Medications currently being taken and mental health diagnoses

The combination of numerical score on the intake form and the intake medical staff's observations (as well as the observations of transport custody staff as applicable) determine the level of urgency for mental health referral, referral type and whether an in-depth screen by an independent mental health provider is required. The more detailed mental health evaluation will be documented on the FCM form specific to this purpose and will be conducted by a licensed independent mental health provider at the facility no later than fourteen days after arrival. Inmates who receive a significant score on the intake instrument or who appear to the intake evaluators to exhibit psychological symptoms of concern will be administered an in-depth evaluation that is documented on the FCM form created for this purpose.

This evaluation addresses: family history, education history, support systems, history of hospitalizations, treatment history, substance abuse issues, criminal history, and potential areas of

strengths. All diagnoses will be documented using the DSM-IV axis system of identification. Depending on length of present incarceration, Axis IV (psychosocial and environmental problems) may or may not be addressed on a case-by-case basis. Fifth digit coding on axis I and II will not be done for specifiers but will be noted for subtypes of a disorder where applicable.

Newly admitted inmates who have a history of serious mental illness or other chronic mental disorder will automatically receive an in-depth mental health evaluation within fourteen days of arrival to the facility regardless of current presentation. The exception would be if the inmate was an interfacility transfer and has been evaluated within the last six months.

FCM maintains computer programming for the structured clinical interview for the DSM-IV (SCID screen for Windows), the structured clinical interview for axis II disorders (SCID II) and the MMPI-II in order to conduct precise in-depth rapid assessment of inmates' mental health when the need arises. These validated, reliable instruments provide an excellent adjunct to the clinician's diagnostic efforts.

Daily sick call requests. Mental health staff will conduct daily triage of sick call requests for mental health services. Those requests or referrals from staff for inmates who require emergency evaluation will be conducted immediately. Routine sick call visits will be scheduled and completed in no more than ten days from the receipt of request. All appointment logs will be maintained using the FCM Inmate Medical Manager electronic system.

In compliance with NCCHC standards, the request for proposals, and FCM's policies, mental health staff will provide a post-admission mental health assessment of all inmates within fourteen calendar days of admission.

Staff meetings. Mental health staff in each facility will conduct weekly interdisciplinary staff meetings chaired by the psychiatrist, psychologist, or professional counselor. Attendees may include nurses, psychologists, mental health counselors, physicians, custody staff representatives, and case managers. Inmates identified as having special mental health needs will be discussed in order to refine treatment planning. Referrals for mental health services may be made by the medical director, psychiatrist, any member of the medical and mental health staff, or any member of case management or custody staff.

Mental health evaluations requested by the Department of Correction. FCM will provide the required mental health evaluations and examinations as requested by the Department of Correction for such services as pre-parole reports, court orders, transfers, institutional review board, and sentence modification. To avoid mental health workers being in the dual role of a care provider and a monitor, FCM will bring mental health professionals form one facility to another as needed.

Crisis intervention and suicide prevention

Staff training regarding suicide prevention and crisis intervention are addressed in pre-service training as well as annually. FCM views crisis and suicidality not as discrete entities but as emergent psychological situations. Both share common features (precipitating factors, mental health issues, etc.) Therefore both are the focus of attention simultaneously in mental health staff

in-service education. Mental health staff (usually an RN or therapy providers, depending upon the facility) provide the education modules for these topics. The outline for suicide prevention and crisis intervention topics includes:

- Categories of mental disorders on axis I and II
- How mental illness causes suicidality, self-harm, and crises
- What staff can do to address each disorder symptom set at each point on the suicide "timeline"
- Suicide prevention myths and facts
- High risk periods in the correction setting
- Predisposing factors to suicide or emotional crisis
- Emotion expressions and behavioral warning signs
- Suicide watch procedures and purposes

FCM will provide a mental health program that incorporates a twenty-four hour a day, seven day a week rapid response to acute crises. The crisis team will include a psychiatrist, psychologist or professional mental health counselor, psychiatric nurse and a physician. Crisis team members will keep each other informed so that the psychiatric, psychological, and medical spheres of care will contribute to managing the inmate's care. FCM's services will include the screening of inmates for mental health problems upon admission to the facility this will allow for immediate hospitalization of severely psychotic individuals or those with high suicide risks and the use of appropriate infirmary housing for mental health observation.

Inmates exhibiting suicidal behavior will be identified and placed in the institutional infirmary under suicide watch by at least one trained correctional officer or transported to another facility with an infirmary. Upon identification of suicidal behavior, the inmate will receive an immediate evaluation by the mental and medical health staff. A psychiatric evaluation will be performed within twelve hours. If an on-site evaluation is not possible, the inmate will be transported to an appropriate facility or hospital. All inmates exhibiting other forms of psychotic or homicidal behavior will be referred to the psychiatrist for evaluation and advice.

If a psychiatric emergency arises after regular business hours, staff will make an immediate intervention that will include:

- Analyzing the situation and giving the inmate time to regain control
- Reassuring the inmate of staff's desire to help him
- Self harm prevention
- Minimizing behavior that is dangerous to the inmate or staff

Any inmate who makes a suicidal gesture or attempt will receive first aid from a first responder, medical staff member, or other trained staff. The inmate will receive a medical staff examination immediately. Potentially harmful items will be removed from inmate's close environment. Reports of all suicide attempts will be forwarded to the warden and the Department of Correction. The inmate will be referred for immediate evaluation by the mental health team.

Medical staff will be on-site or on duty twenty-four hours a day depending upon the facility staffing pattern. An on-call mental health staff member will always be available; a psychiatrist and a

psychologist or professional mental health counselor will be on-call twenty-four hours a day, seven days a week.

Individual and group counseling

FCM strongly supports the policy of directing inmates toward a least restrictive setting via therapy, groups, and education. Staff's ultimate goal is to promote remission of symptoms and enhanced functioning in the correctional community and upon release. Research shows that if inmates are provided the tools and skills to manage their own conditions and have the means to seek help, they will be less likely to repeat the cycle of relapse-offense-incarceration.

FCM's treatment program is multi-faceted. It includes individual and group counseling. Some of the key points of the mental health program include:

- Programming will incorporate cognitive-behavioral and social learning theory as a foundation with inclusion of other treatment modalities as needed.
- Therapy will be structured around individual, group, and psycho-education and pharmacy education groups.
- Individual therapy will be available to inmates assigned by staff or self-referred.
- Group therapy, pharmacy education, and psycho-education groups will be presented in a balanced ratio for inmates. For every group therapy session, inmates will attend two pharmacy education sessions, and two psycho-educational groups.
- Group therapy sessions will be conducted every morning and evening at most facilities (especially the larger correctional facilities). FCM will work closely with staff of the Department of Correction to determine the appropriate facilities for such groups. Certainly, such groups will be provided at the Multi Purpose Criminal Justice Facility, Delaware Correctional Center, Sussex Correctional Institution, and Baylor Women's Correctional Facility.

What about crowded facilities

Inmates will be referred and admitted to groups by the mental health staff. Any inmate deemed stable enough to mentally track a sixty to ninety minute group will be assigned immediately to a group and begin attendance at the next available group session. Inmates who are not sufficiently stable will be assigned to individual therapy initially to tailor session length and content to the inmates' level of functioning. Individual therapy will be available to inmates who require additional assistance regarding group topics or issues that are inappropriate for group intervention. Referrals will be made by group facilitators, other mental health staff, or the inmates themselves.

MH testing

Assessment of inmates may follow several paths. Inmates' diagnoses will be verified by record (past history), nurse intake assessment, and by clinical interview by a psychiatrist, psychologist, psychiatric nurse, or licensed mental health provider. Inmates with questionable histories, symptoms inconsistent with a current diagnoses, or those presenting with new symptoms will be scheduled for clinical interviews. Clinical interviews may include: computer testing, intelligence testing (such as the Kauffman Brief Intelligence Test or the Mini WAIS-III), neuropsychological screening (Neurobehavioral Mental Status Exam, for example) or other tests. All raw test data and reports will be kept in the inmates' files for review and for comparison when retesting is indicated.

Intensive psychotherapy is not needed by most inmates in custody. Some studies have indicated that an emphasis on direct individual treatment is not the most effective use of the scarce treatment resource. In a correctional setting, group pressure and an individual fear of being viewed by others as being "crazy" can discourage the effectiveness of treatment.

FCM will provide services that are unobtrusive and as normalized as possible. Inmates who are identified as having mental health problems will be assigned to a nurse who will coordinate referrals to the facility mental health staff. An individual treatment plan will be established for each inmate based on factors such as the type of mental disorder, ethnic and sociological factors, length of incarceration time, and related elements. Group sessions commensurate with the needs of the offender will be conducted. Sessions will be limited to group sizes of ten. The sessions will deal directly and indirectly with issues such as:

- Victimization
- Socialization to cognitive-behavioral treatment therapy methods
- Importance of adherence to medication plans
- Anger management therapy
- Crisis identification
- Relapse prevention treatment
- Peer relationships
- Development of more adaptive responses in the correctional setting
- Development of more constructive family/social relationships

The professional resources are not as our state. Not realistic to our population

Transition unit services

The transition unit services will focus on inmates' increased self-management of medications and symptoms. Enhancing coping skills and personal responsibility for managing one's illness have been shown by research to improve efficacy of medication compliance and empowerment on the part of clients (or inmates). Cognitive restructuring will play a key role in program tasks. Covered topics are addressed above in the discussion of group treatment. Individual therapy will be provided for those inmates who need additional assistance to benefit from the group therapy milieu or who have issues requiring management before they are ready to behave appropriately. FCM to the cognitive-behavioral premise that most behaviors, whether negative or positive, are acquired the same way through learning and rules of reinforcement and that proper application of these rules can provide for a good measure of success for both inmates and staff.

Mental health structured care unit

Groups for inmates in structured mental health units will focus on topics encouraging the inmates to make efforts to connect with real world experiences and to attempt appropriate social judgments such as:

- Social skills learning to encourage appropriate engagement behaviors and interpreting others' social behaviors
- Current events to encourage connections with the world at large
- Symptom recognition and mental illness education

- Medication management and education and the importance of compliance

The mental health staff will use a combination of medication and therapy (either in groups or individually) to aid individuals to achieve their SMI symptoms baseline. Some inmates in structured care units may not be suitable for groups or repeated, intensive therapy but the mental health team of the psychiatrist and therapist will customize each inmate's treatment plan to fit the needs and symptoms of the inmate.

The number of sessions per week per inmate will depend on the inmate's current mental health stability, the unit population's current psychiatric stability, number of new members to the unit (possible disruption to existing members) and time of the year (holidays for example that may be positively or negatively stimulating). Every effort will be made to provide a therapeutic milieu (via special needs treatment teams and treatment plans) made up of mental health staff, case managers, and corrections staff that will support progress toward lasting changes for the inmates.

The process for recording inmates' activities is described in the mental health records group therapy section of this proposal. This documentation will be recorded at a minimum of weekly for new inmates and monthly for stabilized inmates. Individual interactions with therapists or psychiatrists will be in subjective, objective, assessment, plan (SOAP) note format using DSM-IV diagnostic criteria, labels, and codes.

Sex offender program

Research on current and past sex offender programs (Marshall, et al., 1998) indicates that an inmate must be in a program for one to two years to have a significant effect although some programs (Twin Rivers in Washington, for example) will accept an inmate with six months left on the sentence under the premise that some treatment might lead the inmate to seek community treatment upon release (Gordon and Hover, 1998). Realistically, for program success, the offender should be available to participate at least one year and preferably two years. As offenders who fail to complete treatment are two to six times more likely to re-offend, every effort will be made not to accept inmates with unrealistically short time incarceration remaining.

The program proposed explores the individual's motivation and rewards for offending, reappraising these, substituting new behaviors for securing the reinforcement that the offender obtains from offending, customizing the offender's strategies as created by the offender and other offenders, and practicing strategies under observation by fellow offenders. The time to complete the program could be one and one-half to two years if all sessions occur according to projected timelines.

Following is a program outline:

Block one, preliminary global assessment of individual inmates via one-to-one interview; expected time twelve to fifteen one hour sessions with meetings twice per week

- Pattern of offending analysis
- Relevant biographical history including sexual history
- Social skills evaluation

- Sexual attitudes
- Attribution style

Block two, group psycho-educational meetings and group didactic sessions; expected time fifty to fifty-five ninety minute sessions with meetings twice per week (education alternates with didactic sessions with a maximum group size of ten and a minimum of five)

- Male and female sexuality myths, facts, and personal perceptions
- Social skills training
- Retargeting power and blame needs appropriately
- Patterns of offending and evaluation of personal cycle of offending
- Pornography--effects, inaccuracies and other topics learned from this class of media
- Truths about sexual function for men and women
- Seeking alternative answers to needs met by offending
- Empathy training/victim awareness
- Relapse prevention strategies (built by inmates for each other)

Block three group didactic sessions fifty-five ninety minute sessions, meeting once per week (maximum group size ten and a minimum of five)

- Role play specific crime events with group critique of narrative "explaining" why event occurred
- Restructure specific offending event with reality based-explanations
- Role play specific situations in which the inmate is at a disadvantage (events related to personal stimulus to offend)
- Role play specific stimulus situations related to offending using cognitive restructuring, and strategies provided by group or self
- Role play strategies for having needs that drive offending met or substitutions for these needs
- Recognizing environmental and personal social cues related to stimulation/offending
- Closure sessions

At each session or interview contact, written documentation in SOAP note format will be filed in each inmate's file maintained specifically for this purpose. Each group session will have a form addressing measurable, observable, behavioral markers of progress or efforts at progress. Due to the large amount of paperwork, a clerk will be responsible for maintaining all files and documents. Completion of each block of the program will be documented in the file. In no way does completion of a specified block of sessions indicate a guarantee of relapse prevention. No documentation will reflect any such guarantee nor should any be implied. Given the highly variable success rate of any sex offender program, such implications would be unreasonable and imprudent.

Inmates not participating effectively in groups will be returned for individual re-evaluation of their personal cycle of offending, etc. One-on-one sessions will not be provided in lieu of group programming and will be discouraged except for re-evaluation of personal cycles. Inmates will be discharged from programming for failure to legitimately progress in groups or for purposefully diverting other group members from progressing group work.

The overall staffing for this program would be three full-time equivalent (FTE) Ph.D. or licensed psychologists, two FTE master's level social workers or counselors, and one FTE clerk. FCM has extensive information and reference material available for a sex offender program.

Coordination with community mental health providers

FCM will designate one or more FCM mental health staff members as community mental health liaisons. These individuals will coordinate with community mental health staff and other community providers. A centralized contact point for inmates and communities alike provides familiarity and consistency for the inmate and the community providers who will serve the inmate. Such services will be especially important for inmates initially entering a facility and for those returning to the community. Continuity of care is paramount for all inmates, but especially for those with mental health issues. FCM will work closely with community providers in such areas as medication continuation, referral for ongoing therapy, and referral to community support groups.

Response to trauma incidents

FCM interprets this section of the request for proposals to be inquiring about the mental health components of responses to trauma incidents. In such a situation, involved FCM staff will report to their supervisor information about the nature of the incident and degree of significance. This information will also be provided verbally immediately to the facility's warden or designee. All other notifications will be per the chain of command as determined by Department of Correction and the facility warden.

Each staff member involved in the event will write a report of the event, submit it to the FCM medical supervisor and the facility's warden or designee. The reports will describe the event and include a timeline. All report writers include their names, titles, and assignment. These reports will be provided within the next business day to the FCM medical supervisor, warden or designee, and others as appropriate in the corrections chain of command.

Mental health staff will be available to the custody staff, medical staff, and any other facility staff to conduct a defusing session and an incident debriefing support session to mitigate any negative reactions to the event staff may have and to allow staff to "decompress." Defusing sessions (allowing stress reduction) should be no later than one hour after the event activity is over. The time of an event debriefing session will depend on staff availability but will occur no later than two to seven working days post event. FCM's quality assurance staff, for future management planning, will address all medical or service related events in the quality assurance meeting following the event.

Treatment planning, discharge planning, and mental health records

Mental heath treatment plans will contain at a minimum:

- Inmate's name, date of birth, number
- DSM-IV diagnoses on all applicable axes
- Medication information

- Numbered problem list
- Corresponding solution list (goals)
- Staff responsible for assuring treatment goals
- Time frame for achieving each goal
- Outcome codes (for example A=achieved)
- Signature line for inmate or refusal to sign check box
- Signature and title lines for attending treatment team members

Outpatient treatment plans for will be updated every two months. Plans for general population inmates on medications will be update every month. Plans for structured care unit inmates will be for two weeks to one month depending on the inmate's limitations and abilities. A treatment plan may be extended or updated depending on the success or lack of progress made by the inmate. The treatment team may include: therapist, psychiatrist, custody staff, and case managers. This will vary by the facility size, scope of services provided, and types of inmates housed at the facility.

Prior to discharge, a mental health liaison will determine the inmate's destination after release and make contact via telephone or fax for services and providers suited to the inmate's diagnoses. Where possible and appropriate, an attempt will be made to secure a post-release mental health service appointment date and time for the inmate. The inmate will be kept informed via the liaison or therapy provider of community connections and the liaison's activities for continued mental health and other services.

Discharge plans will contain at a minimum:

- Inmate's name, date of birth, number
- DSM-IV diagnoses on all applicable axes
- Treatment goals attained while incarcerated
- Suggested local provider services in inmate's home area including address, contact name, and telephone number
- Appointment dates if scheduled prior to release
- List of available AA and NA meeting places and times in inmate's home area, as appropriate
- List of other community resources applicable to the inmate

Staff will maintain a file on every inmate treated by the mental health staff. This file will insure documentation by the mental health staff of treatment programs. All mental health files will be maintained according to Department of Correction requirements. Progress notes will be written in the SOAP note format that includes a treatment plan encompassing current, short-term, and long-term plans (where applicable). All mental health entries will include a DSM-IV diagnosis and numerical code where appropriate.

For those inmates referred for group therapy, the individual case file will be arranged in the order of problem, intervention, evaluation, and plan. The problem section indicates the issues that are identified by the treatment team and are noted on the treatment plans and are to be addressed by the activity therapy staff. Interventions include documentation in the individual or group sessions the inmate is scheduled to attend. Notes indicate the inmate's attendance, the group name, group frequency, and group dilatation. The evaluation section states the inmate's progress toward

meeting the treatment goals and objectives. Staff note those interventions the inmate has responded to (for example participation, interaction, task orientation, attitude, and processes). The plan states the updated treatment goals and course of treatment. Each inmate's file will be continually updated and available for all health care providers. The file will be forwarded to the appropriate facility if the inmate is transferred.

FCM's mental health team will maintain records and files in a condition that will be readily available for audit by the Department of Correction or NCCHC auditors. Those files will be set up to meet the general requirements of the NCCHC and will include documentation of policy, procedures, and practice in compliance with the requirements of the request for proposals. Each file will contain the primary documentation and the secondary documentation. Primary documentation includes the policy, procedure, and protocol that staff is required contractually to meet. Secondary documentation includes documents that can verify compliance with policies and procedures. The mental health team will also conduct mental health chart audits and peer review evaluating performance adherence to prescribing and treatment guidelines.

4. Prescription Drug Program

Prescription drug program

FCM policy A-24, in compliance with NCCHC standards for prisons, discusses all aspects of prescription drug services. Also, the above section, medication distribution and procedures, discusses many aspects of FCM's prescription drug program. Currently, FCM uses a national pharmacy service in most of its facilities. However, in others, it works with local pharmacies to prepare and deliver medications. FCM is also eager to work with the subcontracted pharmacy vendor as soon as possible after vendor selection. Because FCM has extensive correctional pharmacy experience, staff will be able to assist the vendor in all aspects of correctional pharmacy. Topics include packaging, distribution, accountability, etc. specific to the correctional setting.

Tampering of medication or tools

FCM will provide to security staff, as directed, a daily inventory of tools and medicine. FCM has in place procedures for tool and medicine control. The procedures include dental tools, syringes, and keys. Policy A-16 details maintaining an inventory of such items. The policy calls for a daily inventory of all needles, syringes, tools, and instruments. It also outlines the recording of all completed inventories.

Attachment 11 is FCM policy A-16 with four attachments: the equipment, tools, sharps count verification form; the medical needle, syringe, and sharp control record for bulk stock; the needle, syringe, and sharp control record for bulk stock; and the dental needle, syringe, and sharp control record for bulk stock.

Tuberculosis medication program

Inmates being treated for tuberculosis will have their medications administered in accordance with the document, *Control of Tuberculosis in Correctional Facilities;* U.S. Department of Health and Human Services; Public Health Services; Centers for Disease Control and Prevention (CDC);

updates or revisions of any of these documents; and any specified regulations of the Department of Correction. In addition, FCM will work extensively with local departments of health. FCM believes strongly in closely coordinating with them as part of not only the inmates' continuing health but the public's health as well.

FCM has developed and maintains a several hundred page *Infection Control Manual.* In addition to policies and procedures, major divisions include: infection control program, infection control committee, bloodborne pathogen exposure control plan, tuberculosis exposure control plan, tuberculosis skin test and interpretation, employee tuberculosis testing, standard precautions, isolation procedures, hand washing, medical supply decontamination, disposal of sharps and syringes, medical waste management, personal protective equipment, spill kits, and reportable diseases. The manual is updated regularly. All of these documents are in compliance with ACA and NCCHC standards.

FCM policy CID 1.4 is specific to the company's tuberculosis exposure plan. The stages outlined are screening, containment, and treatment. The policy has multiple forms that are used in the facilities including the inmate tuberculosis and immunization record and the tuberculosis yearly declaration of symptoms form. Further, FCM has an inmate education program for tuberculosis; HIV; and hepatitis A, B, and C. Any inmate identified with HIV, AIDS, tuberculosis, or hepatitis is placed on the special needs roster to receive a nutritional analysis and plan.

The CDC recommended regimen for preventative therapy for adult inmates with tuberculosis is 900 mg isoniazid and 150 mg vitamin B6 twice per week given orally, with direct observation therapy for six months. Preventative therapy is always by direct observation; keep on person is not appropriate for this therapy.

Due to the increase in multi-drug resistant tuberculosis, inmates with confirmed tuberculosis or highly suspected of having tuberculosis should be started on four drug therapy of isoniazid, rifampin, pyrazinamide, and ethambutol or streptomycin until drug susceptibilities are known. Daily dosages are determined by the medical provider.

For any inmate with a positive PPD or exhibiting the signs and symptoms of possible tuberculosis, staff will isolate the person immediately and contact the appropriate medical provider for orders. Inmates who will remain at a facility for forty-eight hours or longer (or all inmates if directed by the Department of Correction) will receive a PPD test to determine their tuberculosis status. The tuberculosis skin test given to all inmates is purified protein derivative (PPD). FCM policy CID 1.4.1 details the policy and procedures for use of this test.

HIV and AIDS medication program

FCM has a comprehensive program related to HIV and AIDS. FCM views HIV disease as a spectrum. Therefore, the policies, procedures, and activities do not focus just on AIDS which the company defines only as the end stage of the disease. The policy discusses all components of this spectrum. The following addresses only medications.

FCM will coordinate with the selected pharmacy provider in providing medications to all inmates diagnosed with HIV or AIDS, as defined by the Centers for Disease Control and Prevention. FCM

follows the HIV and AIDS treatment guidelines of the Centers for Disease Control and Prevention and the U.S. Department of Health and Human Services Panel on Clinical Practices for the Treatment of HIV Infection and the Guidelines for the Use of Antiretroviral Agents HIV-1 Infected Adults and Adolescents. If these are in conflict with the treatment medications of the National Institute of Health, as outlined in the request for proposal, FCM will meet with staff of the Department of Correction to determine which is preferable. FCM will also coordinate with the Division of Public Health to access and utilize HIV and AIDS medication programs available through the Division of Public Health.

FCM Policy CID 2.5 outlines procedures including education, screening, and medical management. All inmates who are diagnosed with HIV or AIDS will be monitored in the chronic care clinic at least monthly. Newly diagnosed inmates will be referred for a nutritional screen and nutritional education as well as the recommended medication regimen and serology testing.

Reduction of psychotropic medication dependency

FCM policy M-1 discusses psychotropic medications indicating that psychotropic medications are prescribed only when clinically indicated as one facet of a program of therapy. In all instances, psychotropic medications are prescribed only by a medical provider following a physician exam. All such medications are administered as direct observed therapy under the direction of the health authority. Inmates on psychotropic medications will be evaluated at least monthly by a mental health clinician and a psychiatrist.

FCM firmly believes that although psychotropic medications are appropriate for many inmates, their use must be strictly monitored. To that end, health services staff will not routinely prescribe (or continue to prescribe) these medications unless they are medically indicated. FCM has been successful in decreasing the use of such medications in facilities it operates. FCM will work in concert with staff of the Department of Correction in reducing inmates' dependency on psychotropic medications.

Developing, monitoring, and updating formulary

FCM has a formulary that is the base of all formularies in all facilities it operates. As needed, FCM will work with staff from the Department of Correction, the subcontracted pharmacy vendor, and those involved with the Delaware pharmacy plan to revise FCM's formulary. The formulary will meet Medicaid and Medicare standards and be in accordance with the statewide pharmacy contract. FCM understands that the formulary is subject to approval by the Department of Correction.

Handling charge or fee load

FCM has no separate handling charge or fee load for prescription charges. The handling is part of the salaries of all staff who provide pharmacy services such as the FCM pharmacist, nurses who distribute the medications, others who process orders, etc.

Every inmate entering a facility of the Department of Correction will receive an initial health assessment or intake. The intake process includes information regarding the inmate's

medications, health condition, and allergies to foods and medications. All of the information obtained during the intake process is used by health services staff to make assumptions regarding the person's health. For instance, a person allergic to aspirin would not be prescribed medications containing such medications.

As part of FCM's risk management program, all drug errors and drug interactions and reactions are investigated. The information is reported at the quality management committee.

It is important to be aware of food and medication allergies and the type of reaction experienced in the past. Throughout the health care continuum, there are markers to alert the health care provider to inquire about allergies. For example during all health assessments, inmates are asked about allergies as well as during sick call, especially if a health care provider is considering prescribing medications. Allergies are also transcribed in the physician's order form, on every nursing protocol, and on chronic care clinic assessment forms. Further, each medication administration record (MAR) is pre-printed to note allergies.

Note that FCM's current pharmacy provider will not even fill a prescription unless the allergies are listed. They will not accept a blank space but require an entry of "NKA" (no known allergies). The pharmacy provider completes an inmate profile on every inmate whether there is one order or ten. They review every inmate's profile prior to filling any order to check for allergies or drug interaction possibilities. If there are any questions, the pharmacist will call for verification. This procedure is common to all pharmacy providers.

Attachment 12 includes three forms used to assess inmates: the pre-booking assessment record, the intake mental health screening form, and the standard intake screening form. All of these forms inquire about medications. The forms also provide health services staff additional patient profile information.

Patient drug record

FCM uses a standardized, pre-printed medication administration record (MAR). This form includes:

- Several areas for unit dose medications administration by calendar day
- A legend tailored to the corrections environment (such as "O" for out to court or "L" for lock down)
- Areas for KOP medications (to be signed by the innate)

Attachment 13 is FCM's medication administration record (MAR) form. MAR

Data elements

Standard data elements include:

- Name of medication
- Prescribing provider

- Dosage
- Start date and ending date
- Route
- Prescriptive instructions

Contemplated enhancements to patient profile and drug record system

FCM is investigating a bar coding system to track medication administration. Such a system provides for a more accurate and secure system for medication administration. It is also extremely valuable in maintaining records of medications.

Ability to link with subcontractor

Administrative and facility staff will have no difficulty working with the to-be-selected pharmaceutical vendor as it has similar arrangements in all other facilities that the company operates.

Enforcement of quality standards for subcontracted pharmacy

FCM and the subcontracting pharmacy will adhere to the Delaware's pharmacy regulations. In addition, FCM:

- Supports the use of pharmacy tech staff
- Requires competency based training
- Performs complete monthly medication compliance audits
- Monitor for medication administration and drug reaction events monthly
- Monitors, via the QA program, MAR documentation audit quarterly
- Monitors, via the QA program, medication administration quarterly
- Monitors the pharmacy process monthly

If any item that falls below the established threshold, the health services administrator, quality assurance nurse, or pharmacy staff will investigate, will complete an action plan, educate appropriate staff as indicated, and re-evaluate progress in improvement.

Generic grade

FCM requires standard generic medications but of course uses only FDA approved ones.

Approval or denial of non-formulary medications

Per FCM procedure, medical providers must use formulary drugs when possible. To deviate from the formulary, facility staff must complete the non-formulary request form that includes the inmate's name, requested medication, dose, and the rationale for its use and request. The non-formulary request form can also be used to request an unusual medical soft good or laboratory tests. The chief executive officer (or in absence, the on-call physician) must approve all non-formulary requests before the order can be filled.

Attachment 14 is the non-formulary request form that FCM uses in all of its facilities.

5. Dental Services

Overview of dental services

FCM will provide dental care, consistent with community standards, to all inmates of all facilities, by licensed dentists. Such services will also be provided according to NCCHC standards, American Dental Association standards, guidelines of the Centers for Disease Control and Prevention (CDC), and standards of the Occupational Safety and Health Administration (OSHA). Services will include dental screenings within fourteen days of admission, dental examinations within thirty days of admission (in accordance with the request for proposals), and dental services based on the impact of the dental condition on the inmate's health. For dental emergencies, the facility's dentist will consult with appropriate specialists as required.

FCM has en entire section of its policy manual dedicated to dental care (policies D-1 through D-9). These include discussions of dental care, equipment, education, treatment, infection control, periodontal disease, inmate visits, unserviceable dental gold, and routine and emergency care to include dental health orientation. FCM fully intends to provide routine on-site dental clinics at all facilities if possible. FCM will try to avoid transporting inmates from their assigned facilities to receive services. However, if this is necessary, the first choice would be to transport the inmate to a facility that provides dental care. Only in unusual circumstances will inmates be transported to a community provider.

FCM is aware of some of the problems associated with many of aspects for dental services, including the shortage of dentists willing to work in the facilities and the slow progress in making fully functional the dental trailer outside of the Central Violation of Probation Center in Smyrna. Immediately upon notification of contract award and during the transition period, FCM will carefully evaluate the dental services available at each site as well as at the dental trailer in Smyrna. Staff will also explore the current procedures for providing these services at other sites (transporting to other facilities or community providers).

NCCHC standards require a dental screening within seven days of admission to the system and a dental examination and instruction in oral hygiene and preventive dental education within one month of admission. Dental treatment, not limited to extractions, will be provided based on a treatment plan. Inmate dental services will be provided based on whether the health of the inmate would be adversely impacted, priority, and the estimated length of incarceration.

Dental screening

Dental services will begin with the initial health assessment completed for every inmate entering a facility. During this assessment, health services staff will document on the dental screening form the following information:

- Dental history

- Instruction on oral hygiene
- Provision of fluoride toothpaste (if required by the Department of Correction)

Dental examinations

A dental examination by a licensed dentist will be carried out within fourteen days of the initial dental screening and will include:

- Visual observation of teeth and gums, noting any abnormalities
- Examination of the hard and soft tissues of the oral cavity
- Charting of oral conditions to include decayed, missing, and filled teeth, and dental appliances
- Priority classification of dental conditions

Inmates will receive panoramic dental radiographs as appropriate. The dental exam will be conducted using a dental light, dental mirror, and explorer.

Dental treatment

A dental treatment plan with inmate participation will be established. The care plan will include dental objectives, interventions, and methods of evaluation of care. Specific areas of planning include medication, laboratory tests, diet, and health education as appropriate. The treatment plan will categorize care into categories. Category 1 conditions require immediate treatment (within twenty-four hours). Category 1 conditions include avulsed dentition, facial trauma, or acute oral pathology. Category 2 conditions requires priority care. Such conditions, if left untreated, could cause eminent acute infection. Category 3 conditions require routine dental services. They include care to prevent extractions, repair teeth, and prosthetic replacement of dentition.

Prevention

FCM policies D-1 and D-3 discusses not only dental treatment but also preventative dental programs to include a scheduling system to maintain these services. The preventative dental program of FCM includes oral prophylaxis, proper oral hygiene instruction, distribution of dental information, selection of proper dentifrice and toothbrush to control and prevent abrasion, and dietary consideration related to erosion.

A central component of any dental treatment is dental health orientation. Dental orientation, usually provided by a registered dental hygienist, is provided within fourteen days as per NCCHC guidelines. This orientation includes education about the cause of dental disease, tooth brushing and flossing techniques, oral self-care, access to dental care, dental clinic hours, dental priority system, types of dental care provided, and oral hygiene aids.

Referral

The attending FCM dentist will have the autonomy to determine treatment and care of inmates unless such treatment conflicts with the standard security and operational policies of the facilities. If inconsistencies or disagreements occur between the attending dentist and the warden regarding

non-clinical security or operational matters, the final decision will be rendered by the medical director or designee and also addressed in a Medical Administrative Committee meeting, as appropriate. FCM does not anticipate such conflicts, however, because the vast majority of dental care will be provided at the facilities.

However, there are situations that will require referral to dental specialists. These include category 1 emergencies when no dentist is available on-site or for care requiring a dental specialist. Even for services requiring a dental specialist, FCM's goal is to have such providers come to the facilities to provide care.

Emergency treatment

FCM policy D-9 discusses emergency dental care. The policy and procedures direct that during normal scheduled hours, all inmates with dental emergencies will be taken to the infirmary or dental clinic for evaluation (if one is available). Those inmates evaluated in the dental clinic with chronic or acute problems of a non-emergency nature will be treated during the next available dental screening. Those with after hours dental emergencies will be assessed by the nursing staff and the medical director or the on-call physician will be notified of the need for medical care. That person will determine whether the inmate should be transferred to an appropriate emergency facility.

Provision of prosthetics and laboratory services

FCM policy, in compliance with ACA and NCCHC standards, provides that medical and dental prostheses and orthodontic devices will be provided when the health of the inmate would otherwise be adversely impacted as determined by the responsible physician or dentist. FCM will abide by these standards in the provision of dental prosthetics and laboratory services.

Hiring process for dentists

Good plan ✓

FCM is aware of the challenges in hiring dentists to work in the facilities. Several options exist for recruiting dentists. FCM's manager of human resources will establish a comprehensive plan to recruit dentists. This will include a statewide advertising plan, personal contracts with any available dental schools, telephone calls to every dentist in proximity to the facilities to attempt to secure part-time or full-time services, and possibly offering financial incentives such as bonuses. In addition, FCM has a contracted dental consultant, David T. Spence, D.D.S., who has been a subcontractor and consultant with FCM for the past five years. He has ten years of experience providing dental services at correctional facilities including facilities operated by FCM in Texas. It is FCM's experience that service providers are more likely to be persuaded when approached by members of their own professions.

Retention of dentists and provision of services during vacancies

Retention of dentists begins with the recruitment process and continues throughout the tenure of their services. The perquisites provided to dentists, whether contracted or employed, are also vital to retention. Such perquisites include monetary and non-monetary components including continuing education opportunities. FCM is able to customize its pay and benefits to each provider

to entice and retain each person. As it does for its physicians, FCM rotates dentists among facilities to cover vacancies.

6. Off-site Facilities

Use of community hospitals and facilities (referral process, patient information sharing, coordination with transportation and security)

FCM policy A-12 discusses hospitals, indicating that hospital and specialized care for inmates are provided at a designated, nearby licensed health care facility. Services include specialty clinics, diagnostic testing, surgical care, outpatient procedures, lab services, hospitalizations, and physical therapy, to name a few.

Immediately upon notification of contract award, FCM will secure contracts for community hospitals in each area where the Department of Correction has inmates. The contract will spell out the referral process and information sharing procedures. FCM clearly identifies, in each facility, the process for referring an inmate to the designated hospital. FCM tries to have a single point of contact at each hospital to expedite services and assure consistent practices and services.

The referring physician will do as much as possible to resolve the medical problem, either diagnostically or therapeutically, before referring for consultation. Referrals generally will be made only when the clinical findings cannot be managed at the institutional level. When inmates need health care beyond the resources of the facility, they will be transferred under appropriate security provisions to a facility where such care is available.

Any time that health services personnel determine that an inmate needs to be transported off-site, staff will coordinate with transportation and corrections officers. For scheduled appointments off-site to community hospitals and facilities, staff will make every effort to accommodate the schedules of the transportation and corrections staff. FCM's staff including the medical records clerks have always established a good working relationship with the transportation officers and correctional officers. Off-site consultations are coordinated in an attempt to schedule the inmate with enough time to safely move from one appointment to another without jeopardizing security. It is FCM's practice to meet as soon in the contract period as possible with corrections and transportation staff to cement procedures in each facility.

Inmate information is considered confidential and shared only with those individuals who "have a right to know." A copy of the consult request and pertinent medical information is sent with the transport office to give to the off-site provider. Custody information is never released to off-site providers or facilities.

Pre-admission review and certification process (including timelines)

The following discusses pre-admission and review for FCM's current services. When FCM begins providing services in Delaware the process will be customized to allow staff in the Delaware corporate office to handle many of the support functions discussed.

For a pre-admission review and certification, the appropriate provider will complete the consultation request form and send it to the consultation clerk. The consultation clerk will log the request into the consultation log and fax it to the FCM corporate office for approval. Staff will then log the request into the FCM system and the FCM medical director reviews the request. The medical director may:

- Approve the request–turn around time one to two days
- Deny the request–turn around time one to two days
- Request more information in order to make an informed decision–turn around time varies

Criteria for continued stay and follow-up care

Currently, FCM handles these components on a case-by-case basis. As appropriate, FCM will formalize and detail the process.

Sub-acute care and regional acute centers and specialty hospitals

The referring physician will do as much as possible to resolve the medical problem either diagnostically or therapeutically before referring for consultation. Referrals will be made only when the clinical findings cannot be managed at the institutional level. FCM contracts with local sub acute care or regional acute care centers for outpatient, inpatient, and emergency care needs. Patient information sharing and coordination for transportation are discussed above.

Specialty hospitals

The referring physician will do as much as possible to resolve the medical problem either diagnostically or therapeutically before referring for consultation. Referrals will only be made when the clinical findings cannot be managed at the institutional level. Patient information sharing for transportation are discussed above.

Specialty services

FCM will contract with local specialty services, such as radiology clinics. As necessary, a transportation officer and a member of the health care unit will make a site visit to the unit prior to the inmate's transport. The correctional officer will review the facility from a safety and security viewpoint and the medical person will review it for appropriateness of service.

off-site visits

FCM will provide in-service training to off-site services staff to assist them in management of the inmate while on-site. This includes the policy for restraints, contraband, and documentation.

In addition, on-site services are discussed in detail in Section E1 above. Discussed in other sections of this proposal, FCM will contract with the local emergency medical transport providers for all emergency transfers that require ambulance services. FCM recognizes that the Department of Correction will provide all non-emergency transportation and that it is FCM's responsibility to coordinate this service but FCM will not pay for the associated costs.

Patient information sharing and coordination for transportation are discussed above.

Transitioning patients from facility care to long term convalescent care

To the extent possible, patients leaving a facility will return to the correctional facility for convalescent care. If the facility does not have the level of care needed (infirmary, etc.), FCM will work with the Department of Correction to determine if transfer to another facility within the system would be appropriate. If the inmate cannot be accommodated in the system, FCM will coordinate with a contracted long term convalescent care facility.

Pay and fee structure for off-site specialty care including reduced rate contracts with community hospitals

FCM arranges the most advantageous contract arrangements for off-site services. FCM's fee structures include percentage of approved bill charges, Medicaid rates (or percentage above or below), Medicare rates (or percentage above or below), a set fee for a service, a set fee per hour, a specially negotiated fee, or some combination. As an example, for a recently negotiated hospital contract in Arizona, FCM and the hospital agreed that FCM would pay:

- Medicaid plus 10 percent for most routine care
- A set fee per hour for dental services provided on-site at the facility
- Lab services at a pre-determined amount for the most commonly ordered labs
- Lab services at the hospital's fee schedule for all other lab services
- The inclusion in the lab fee of courier service, materials, and supplies
- The pick up of x-rays by the hospital's courier (be read by another subcontractor) as a free service
- Biologicals and inplantables at the hospital's cost

FCM's contracting staff work very closely with staff of subcontractors to determine the most advantageous and equitable rates. FCM also tires to take advantage of economies of scale by using national providers if possible. This is discussed below in the sub-contracting section.

7. Department employee services

Services and procedures for Department of Correction employees

FCM coordinates and cooperates with employees at its facilities at all levels ranging from informal lunches to participation in formal committees. A discussion of coordination and communication is detailed below in section F3. This section outlines medical services that health services staff will provide to staff of the Department of Correction. Such services will revolve around emergency care and educational components.

FCM will provide emergency treatment to staff of the Department of Correction (or others on the premises). Treatment will consist of stabilization and referral to a personal medical provider or local hospital. Examples of services that fit this category are employees with possible cardiac arrest, heart attacks, strokes, loss of consciousness, fractures, and severe bleeding.

The second category of services that FCM will provide to staff of the Department of Correction is educational. This is detailed below.

8. Case Management

Case management plan and procedures

Case management is both a model and a technology for structuring the clinical production process. It also is vital in quality outcomes. By being a multidisciplinary care process, case management achieves a dual purpose in connecting the quality of care and the cost of care. Assisting the health services administrator in the complexity of case management and utilization review is:

- FCM executive staff and business manager
- Contracting agency staff
- Custody staff
- Pre-established local subcontractors

In the correctional health care environment, there are four models of case management:

- Self care
- Clinic care
- Episodic care
- Broken care

The self-care and clinic care case management functions are tracked and monitored through the quality management program functional areas of quality improvement, infection control, and medical staff. These functional areas are based on the premise that the quality of care meets or exceeds the standard or threshold of compliance. The indicators, studies, and peer reviews are the safeguards that identify when an area drops below the standard. The broken care case management function is identified in the functional area of risk management and includes sentinel events.

Large case management services

The most detailed and involved case management service is the response to inmate grievances. Each grievance will be investigated thoroughly and a response sent to the inmate. The health services administrator will track and trend the grievance and identity any breaks in process. Case management is also appropriate for complex, unusual, or expensive health care conditions.

Specialized services

Case management for special needs inmates and those in chronic care is vital. FCM policy A-29 details services for special needs inmates. These inmates can be physically handicapped or have special mental health needs. Examples of inmates with physical conditions are those with mobility impairments, visual impairments, and hearing and speech impairments. Examples of inmates with

special mental health needs are those who have a history of self utilization, psychosexual disorders, aggressive psychoses, and substance abuse. For such inmates, case management, including a written treatment plan, is vital.

Types and identification of conditions for successful case management

Inmates who are most successfully case managed are those who are cooperative and want to manage their own care. Studies indicate that even in correctional settings, patients are more successful if they have an investment in their own outcomes. Treatment of inmates with mental health illnesses or other conditions are discussed in the mental health services sections, above.

Inmates appropriate for case management are identified:

- At the time of intake
- By referral from mental health and substance abuse providers
- From custody staff.
- From other providers, especially post hospitalization

Available case management services

Available specialty case management services include:

- Special needs inmates–temporary or permanent
- Inmate grievances
- Inmates recently hospitalized–outpatient or inpatient
- Inmates returning from off-site specialty clinics
- Inmates receiving on-site specialty clinic care
- Those appropriate for utilization review

Criteria for referral to case management

The two most common criteria for referral to case management are based on the individual needs of the inmate or risk to the inmate. An example of case management based on an inmate's needs is the provision of case management for an inmate returning from an inpatient hospitalization for surgery. An example of case management for an inmate to decrease risk to the inmate is providing case management to a potentially suicidal inmate.

Communication with Department of Correction regarding cases

Ongoing and active communication will take place between FCM and the Department of Correction to resolve inmate health care issues, including case management.

Referral of case from Department of Correction

FCM not only allows but encourages the staff from the Department of Correction to refer inmates for case management. FCM recognizes that custody staff often are more knowledgeable of

inmates' conditions than the health services staff, especially as custody staff often see the same inmates frequently and for longer times.

Cost benefit analysis

The literature of managed care and health services in general has documented well the cost effectiveness of managed care. This is particularly true in correctional settings where patients can be monitored for compliance. Further, cost benefit analysis extends beyond immediate monetary components to address areas such as improved health outcomes, preventative care, and future savings from staff education. Although FCM has not directly tracked savings from case management, staff is quite willing to collaborate wit the Department of Correction to begin collecting such information as needed.

Expected results

Some of the expected results of successful case management include:

- Behavior modification
- Clinical intervention
- Cost savings
- Health risk assessment and decrease
- Prevention and wellness
- Practical guideline development
- Compliance monitoring
- Staff (provider and professional staff) education
- Pharmaceutical formulary development and modification
- Community outreach programs for compassionate release
- Individualized care based on the complexity of the event
- Appropriateness of care
- Faster authorization of services
- Shorter hospitalizations
- Better communication and working relationships with off-site subcontractors, providers, and hospitals

Case studies of successful case management

Following are examples of inmates who FCM successfully case managed. In the first example, an inmate was diagnosed with liver cancer. FCM worked with the hospital staff to establish an accurate diagnosis and to determine the appropriate date to transfer the inmate from an acute care hospital back to the correctional infirmary. FCM also collaborated with the hospital's medical staff to meet the inmate's needs while detained in the observation unit when returned to the facility. FCM's case management staff worked with the mental health staff and the custody case manager to establish rapid compassionate release for the inmate.

In this example, savings were realized by moving the inmate as quickly as appropriate from the acute care setting to a less expensive correctional infirmary. Savings were also realized by releasing the inmate early from the correctional setting to appropriate post release follow-up.

In the next example, FCM case management staff analyzed a hospital bill for an inmate hospitalized because of a lacerated liver. The inmate received various intravenous and oral narcotics during a short time period. Hospital staff did not require the inmate to get out of bed and practice deep breathing exercises because the inmate was cuffed and the hospital workers did not know how to have the patient exercise. As a result of not moving sufficiently, the inmate had post operative pneumonia.

Staff reviewed the inmate's case for appropriateness of care. FCM identified several educational opportunities that were subsequently incorporated into a staff in-service segment. Also FCM trained the hospital staff, with the assistance of custody staff, in how to provide appropriate post operative normal patient care treatment plans, even for restrained patients. In addition, the health services administrator discussed the care with the hospital staff. Future savings would be realized by avoiding longer and costly care for the inmate both because the length of hospitalization could have been decreased and the cost of post operative pneumonia care could have been eliminated.

Site visits (including examples)

At one of its facilities, an inmate was hospitalized for valley fever, a serious respiratory condition. The inmate was on a ventilator and also had bilateral chest tubes. A health services provider from the hospital came to the prison to complete a site visit. The primary objectives were to review the chart and to assess the actual physical and environmental condition the inmate was transferred from and would return to.

Advantages of site visits in general are that providers can:

- Obtain more accurate information
- Interview staff
- Review medical records for more complete information
- Evaluate the physical environment
- Answer questions of hospital staff regarding custodial health care (building better relationships)

F. Contract Responsibilities

1. NCCHC Accreditation

Maintenance of accreditation

To ensure maintenance of the facilities' accreditation FCM will, immediately upon contract award notification, prepare a plan and timeline for all components of the process for each facility. This effort will be spearheaded by FCM's director of clinical services. The first step will be to examine all documents in each facility that are related to NCCHC accreditation and immediately begin the process to integrate FCM's policies and procedures as appropriate.

FCM adheres rigidly to ACA, NCCHC, and JCAHO (as appropriate) guidelines in all of its operations. Likewise, FCM adheres to CDC and NCQA guidelines and recommendations. To that end, staff has established an in-depth master policy and procedures manual that is customized to the specifications of each of its customers' facilities, inmates, and other specific needs. The manual is maintained in the medical department of each facility and is accessible to all staff at all times. FCM policy details the process for altering, updating, and reviewing annually the documents.

FCM is well qualified and experienced in preparing for and meeting NCCHC and ACA accreditation standards. One key element for this is the company's policies and procedures and supplemental documents that are specific to such guidelines. The following paragraphs discuss the company's experience in securing and maintaining accreditation.

FCM provided professional services at the Bartlett State Jail in Bartlett, Texas, from August 1997 through April 2000. The NCCHC accreditation committee met and approved accreditation of the facility February 18, 1997. The auditors made recommendations for improving care. FCM staff identified opportunities for improvement and worked with other medical staff to implement the changes. FCM staff were also instrumental in the NCCHC's three year cycle site survey. In preparation for this, staff helped review files as well as policies and procedure for NCCHC compliance. Staff also set up formal mechanisms for tracking inmates' examinations, chronic care clinics, mental health examinations, etc., to ensure meeting the requirements of the site survey.

At the Lake Erie Correctional Institution in Conneaut, Ohio, the medical services component provided by FCM scored 100 percent on the facility's 2001 ACA audit. To accomplish this, FCM gathered, organized, and presented all relevant information for the fifty-seven health-related ACA standards. The entire process, from hiring of the first employee through achieving ACA accreditation, required only eleven months. Success was facilitated because FCM developed a close collaborative relationship with the facility's custody staff.

In Ohio, state officials perform formal internal management audits every six months to ensure compliance with state and ACA standards. The Ohio management audit, conducted by the Ohio Department of Corrections, includes specific medical and mental health professionals as well as the wardens. During the October 2001 audit of the Lake Erie Correctional Institution, FCM scored 100 percent.

FCM has operated the North Coast Correctional Treatment Facility in Grafton, Ohio, since July 2001. The facility's initial ACA audit will occur in May 2002. FCM staff is taking all steps necessary to ensure that standards will be met, including a full mock facility audit scheduled for February 2002. Similarly, FCM passed a formal Ohio mental health audit in November 2001.

FCM provided medical services for the Eloy Detention Center in Eloy, Arizona, from February 1996 through September 2000. The medical facility received ACA accreditation in May 2000. FCM carried out all components of the preparation and execution of the successful audit. This included ACA file creation, policy and procedures development to ensure compliance, and increased staffing coverage to complete all functions.

At the Central Arizona Detention Center in Florence, Arizona, FCM compiled material for all functions to verify compliance with all ACA requirements. Four weeks after FCM left as the facility's medical services provider, the facility received ACA accreditation. This was an exceptionally complex audit as the facility housed 2,600 male and female inmates from four jurisdictions–Alaska, the U.S. Marshals Service, Washington, D.C., and Montana.

2. Performance Guarantees

Achieving and monitoring performance guarantees and working with the Department of Correction to achieve guarantees

FCM takes very seriously all aspects of correctional health care. As discussed throughout this proposal, FCM's record is outstanding in the very small number of law suits, fines, and other contractual issues. FCM above all else takes seriously the provision of appropriate health and medical services. To that end, FCM will easily meet the performance guarantees outlined in the request for proposals. One of the keys to all performance by health services staff is cooperative work with the staff of the Department of Correction. As a specific example, as discussed below, reading tuberculosis tests requires cooperation of custody staff to grant health services staff access to the inmates. From a larger perspective, custody and health services staff must work cooperatively in almost all components of health services for FCM to maintain NCCHC accreditation.

Per Guarantees

Specifically, FCM will easily maintain NCCHC accreditation. The above section details FCM's experience in meeting, obtaining, and maintaining various standards. Staff do not fear such processes but welcomes them as they can provide valuable information regarding changes that can improve care and decrease expenses.

This proposal has discussed extensively the provision of inmate tuberculosis testing. In the cost containment section, FCM agreed to testing every inmate if the Department of Correction required but recommends that staff test for tuberculosis for new admissions only if documentation of a transferred inmate verifies no previous testing. Further, FCM will read all tests within seventy-two hours of admission. Note that providing such readings requires cooperation with custody staff. If custody staff is unable or unwilling to locate an inmate or provide medical staff access to the

inmate (either in the health services unit or in a housing unit if the inmate cannot leave that area) FCM would not be fined the $2,500 for a missed read.

Immediately upon contract award, FCM's transition team will meet with appropriate staff of the Division of Public Health. The purpose of the meeting will be to ensure that FCM's communicable disease reporting policies and procedures are in accordance with the Division of Public Health's requirements. FCM will ensure that every health services provider knows and follows the prescribed procedures.

Response to letters of non-compliance or letters of concern

FCM does not anticipate receiving a single letter of non-compliance, let alone four such letters that would lead to a monetary penalty. On-site staff will be directed to notify immediately the following FCM employees of a letter of non-compliance: the facility's health services administrator, the FCM director of operations, and the FCM chief executive officer. Immediately these three employees and others deemed appropriate will meet to discuss a plan of action. Within twenty-four hours of receipt of such a letter, FCM will respond to the Department of Correction with a plan of action.

Suggested incentives

FCM does not expect to receive any special payments or other consideration for providing appropriate services. All services meet NCCHC and other appropriate standards and complies with all contract requirements.

3. Coordination and Communication

Coordination with the Department of Correction in general

FCM embraces a collaborative relationship with all Department of Correction staff involved with correctional health services. To that end, FCM staff will maintain regular communications with each facility's warden or designees and with the appropriate administrative staff of the Department of Correction. FCM facility and corporate staff will actively cooperate in all matters pertaining to this contract. The most appropriate mechanism for ensuring collaboration and coordination will be a solid relationship with a base being the Medical Administrative Committee (MAC) meetings. FCM looks forward to coordinating these meetings.

FCM encourages the concept of open and collaborative relationships among its own staff as well as with all representatives of its customers. These are not simply hollow words but FCM's way of conducting all of its business. FCM's corporate staff is always closely involved with staff at the facilities it operates. For example, during the recent start-up of services in Ohio, the director of operations lived near the site for several weeks during implementation. Similarly, corporate management visits every facility on a regular basis.

To enhance communication, FCM will establish a corporate office in Delaware. This will allow both staff assigned to the health services units and corporate staff to be actively involved in collaborative activities. This will provide the Department of Correction immediate, and routine staff involvement at all levels. FCM facility and corporate staff will actively cooperate in all matters

pertaining to this contract. FCM mandates such behavior in both practice and in policy. Corporate staff also provide a myriad of services for the facilities such as human resources management, ordering, inventory control, etc.

Coordination with the Department of Correction regarding transportation

FCM recognizes that the Department of Correction is solely responsible for any type of movement of inmates within facilities and outside of facilities. This include emergency and routine situations. Long before health services staff needs to transport an inmate off-site, management staff will establish an initial meeting with the appropriate custody staff to establish procedures and continue to meet on a regular or ad hoc basis. The initial meeting could be within the Medical Administrative Committee (MAC) setting or set as a separate meeting. FCM will refine its procedures for emergency and non-emergency transportation but will work closely with the Department of Correction to limit such transports.

Because FCM is committed to decreasing substantially off-site transport of inmates, whenever possible, FCM contracts with providers to come to the inmates instead of taking the inmates to the providers. Only in unusual circumstances will inmates be transported from the facility for services. Conditions that cannot be treated adequately in the facility may include level one trauma care, outpatient same day surgical services, inpatient acute care, and mental health acute crisis management. FCM will contract with local qualified emergency medical transportation services for all emergency transfers that require basic or advanced life support services.

When an inmate has a potential life threatening medical emergency, a registered nurse or other medical services provider on-site will assess and triage the inmate and communicate with the facility's medical director or on-call physician. That person will indicate the type of transportation required and authorize the transport. To the extent possible, inmates will be transported to contracted hospital but they may be transported the closest hospital if the inmate's condition warrants.

FCM will work cooperatively with custody staff in establish facility-specific procedures for summoning EMS providers. FCM's experience indicates that it is appropriate to notify the duty officer who will initiate an EMS response. Notification first of security staff will allow them to act appropriately to allow the ambulance to enter the facility.

Coordination with the Department of Correction regarding security

Very simply, safety and security are the primary goals in the correctional environment. Even in an emergency situation, FCM fully understands that maintaining security is the priority of all staff. To accomplish this from a health care perspective requires an understanding of how to deliver health care within the secure environment while simultaneously dealing with a population that can be manipulative and a constant drain on medical resources. FCM is committed to on-going efforts to maintaining security as the primary goal of every institution.

Coordination with the Department of Correction regarding training

The staff orientation section below discusses training of health services and security staff to include mental health components as well as forty hours of security and medical practices training. FCM will co-ordinate with the Department of Correction's security staff to ensure their inclusion as a key element of orientation. Vital topics include security practices, chains of command, and security in the medical services areas. FCM anticipates that the Department of Correction would provide approximately eight to sixteen hours of training to health services staff.

FCM also has a comprehensive training program for correctional officers that it could present–modified if requested–to employees of the Department of Correction. Topics include:

- Recognition of signs and symptoms, and knowledge of action required in potential emergencies
- Four minute emergency respond time
- Methods for obtaining assistance from the medical unit
- Signs and symptoms of mental illness, mental retardation, and chemical dependency
- First aid and cardiopulmonary resuscitation
- Emergency transfers
- Infectious disease

Example and resolution of responsiveness and efficiency in coordinating transportation, security, coordination and communication

The following example demonstrates FCM's responsiveness and efficiency in an incident related to transportation, security, coordinating, and communicating. The identified problem, though serious, established improved communications and procedures. The captain, in a memo to FCM regarding FCM's plan for action indicated that "this is a more than reasonable response. I greatly appreciate your acknowledgement of its importance and your prompt reply."

Recently, in a detention facility in which FCM provides health services, the nursing supervisor determined that an inmate required emergency transportation off-site. The nurse called 9-1-1 for emergency medical services but failed to notify the transportation officer that an ambulance was arriving. As soon as the captain responsible for the detention center contacted FCM to discuss the call, FCM's staff:

- Immediately arranged a conference telephone call with all appropriate FCM medical and management staff
- Set a meeting for the next business day with security and health services staff
- Set a meeting for local emergency medical services providers to come to the facility both to meet with staff and to tour the facility to understand accessing the facility
- Arranged for the nursing educator to prepare both a standard operating procedure and an in-service education session related to the issues presented

Daily informing of staff of each facility (including title of single point of contact)

Immediately upon contract award, FCM will meet with management staff of each facility to determine the desired daily communication mechanism. Each facility will have a designated health services administrator who will be the single point of contact for the facility. However, FCM will also provide a list of staff, corporate and facility-based, who are available. Further, FCM has a physician on-call twenty-four hours per day for every facility that it operates and will ensure that the appropriate staff of each facility and the Department of Correction has the correct telephone number for contacting the provider.

Coordination with providers, particularly substance abuse treatment provider

The substance abuse providers are certainly part of the health care team as the health services staff are part of the substance abuse treatment team. Even though the Department of Correction has executed a separate contract for substance abuse services, FCM intends to carefully coordinate with them for patient care. This will include: referring inmates for services (from either substance abuse or health services staff), interdisciplinary case meetings regarding specific inmates, coordination of medications and other care, treatment plans, discharge planning, and so forth.

FCM will work with other providers in the facilities, as it does at all of its facilities. This includes food services staff, maintenance workers, and outside service providers (such as electricians, lock smiths, equipment repairers, etc.). FCM is aware that not all workers in a facility are security staff and will work with them respectfully and cooperatively. These include workers in areas such as information systems, records, shipping and receiving, and support. FCM recognizes that all workers and classification of workers have their own responsibilities and chain of command but sees the entire group as part of the whole system of workers. To this end, FCM encourages its employees to work cooperatively in formal and informal activities such as lunches and other celebrations.

Coordination with providers in the community (specialists and community mental health) while in custody and at discharge

FCM does not simply provide services in its facilities, its staff and services become a part of the health services community. This includes both administrative and facility-based staff. Primarily from its corporate office in Delaware, administrative staff will work closely with all types of health services providers to become part of the FCM health care team. The emphasis will be obtaining contractual agreements for hospital, mental health, specialty care, and other community services for inmates. All of these services and personal relationships are essential for services at the facility, off-site while the inmate is incarcerated, and when the inmate returns to the community.

Treatment and continuity of care will begin during the intake process. This process will include initiation of treatment plans as appropriate (including timely referral to on-site chronic care clinics), referral for communicable disease follow-up as needed, and mental health appointments. Treatment and discharge planning are all part of this same continuum of care and continuity of care that inmates receive. Some of the components of continuity of care include documentation of all patient contacts, transfer of inmates' health records, providing copies (sealed for confidentiality) of health records for off-site medical care, and referral for designated infectious diseases (such as tuberculosis). Immediately upon contract award, FCM will aggressively work to establish positive,

mutually beneficial relationships in each of the communities. This process will continue throughout the contract's duration.

Response to public inquires and coordination with the Department of Correction

It is FCM's policy to refer all public inquiries to the appropriate facility officials. FCM will confirm that this is the desire of the Department of Correction.

Medical Administrative Committee (MAC) meetings

FCM will discuss with the Department of Correction their desires for FCM to coordinate both the individual MAC meetings and the county-wide meetings. Early in the contract term, weekly meetings would be appropriate. After operations are smoothly functioning, bi-weekly or monthly meetings would be appropriate. The health services administrator of each facility will be responsible for all aspects of the meeting including coordination with the Department of Correction.

In general, the meetings would include regularly discussed topics, outstanding issues from previous meetings, and current or new issues. Topics may include discussions of health care services, quality improvement findings, infection control efforts, and environmental inspections. Each month, FCM will include a record of findings of the monthly facility inspections.

Participants will include the warden or legally designated designee of the facility or facilities, the health services administrators, and other designated health care providers. One health services staff person (support or health services) will have the responsibility for preparing the agenda for each meeting and then preparing and distributing the minutes.

In compliance with NCCHC standards, FCM also ensures regular meetings of health services staff as an adjunct to the MAC meetings. Besides discussing facility-specific issues and concerns, staff review and compile statistical information.

Coordination with Medical Review Committee

FCM will fully cooperate with the Medical Review Committee including attending meetings as requested and responding immediately to any problems or non-compliance issues. The health services administrator for each facility will be the single point of contact for coordinating with the Medical Review Committee. However, as discussed, above in the non-compliance section, if an issue is identified at this level, not only the health services administrator of the facility but also the corporate chief executive officer and director of operations will meet immediately to formulate a response and plan. They will respond to the committee within twenty-four hours.

4. Equipment and Supplies

FCM staff had extremely limited time and opportunity to analyze the existing equipment and supplies during the three days of visits to the nine facilities. Unfortunately, the list of all equipment was not provided until after the facility visits. Thus, staff could not compare it to the list to the existing equipment. Essentially the information is inadequate for FCM to project needed

equipment and supplies and their cost. In addition, FCM is unsure what items the current vendor will leave for the replacement vendor.

Equipment

This proposal recommends that FCM purchase and maintain ownership of any items costing under $500 and the Department of Correction purchase and maintain ownership of any items over $500. Fixed items (such as dental chairs) would be the sole responsibility of the Department of Correction to purchase and maintain.

Immediately upon contract award, FCM will began an in-depth analysis of the current system of providing services. Within the first few weeks of operation the transition team will have analyzed the existing equipment and supplies and established a plan for modifying, adding, or deleting various components.

Inventory procedures

FCM staff will not only conduct an initial inventory of all equipment but will also maintain an ongoing inventory of the equipment. The inventory will also track any equipment that is added, damaged, becomes obsolete, is replaced, etc. This inventory information will be readily available for Department of Correction staff to review.

One component of FCM's successful cost containment programs is the "just in time" system of inventory. Health care units must have soft good supplies available for routine treatment of inmates and for emergency care. Medical care soft goods include crutches, ace wraps, sterile dressings, sutures, etc. FCM receives better prices when the company purchases in bulk and shipping costs are likewise reduced. Keeping these factors in mind, FCM has been able to maintain a fluid level of supplies needed for day-to-day operations. The level is based on the inmate population, historical usage, and cost savings volume. The corporate office staff reviews all requests from facilities. They ensure that an inventory request does not exceed the pre-established "par" level. Keeping in mind the turn around time of three to five business days, the supplies are ordered in the correct amount and time sequence.

5. Security

Securing work area, equipment, and supplies

In general FCM will ensure that its work areas, equipment, and supplies are kept secure and that information pertaining to security matters and inmates' health are appropriately controlled. FCM will not leave unattended or unobserved inmates or employees of the Department of Correction in any of the following areas:

- Examination and treatment rooms
- Medicine rooms and closets
- Dental areas
- X-ray rooms
- Counseling and interviewing areas
- Medical office areas

- Medical storage areas

In addition, FCM will properly control access to assigned work areas. Inmates will not be permitted unescorted access except to authorized or established waiting areas. All medication rooms will be locked at all times when not occupied by health services staff. No non-FCM personnel will be permitted access to a medication or office area except to provide housekeeping, maintenance, or other assigned duties under the direct supervision by a health services employee. FCM understands that unless approved in advance by the site manager, an FCM employee will be present during all visits by Department of Correction employees, special authorized visitors, or inmate workers.

Tool and medicine control policies and procedures including daily inventory

FCM policy A-16 details FCM's policy for inventorying instruments, tools, syringes, needles, and blades. Policy A-24 details pharmaceuticals. FCM will coordinate with security staff to ensure that the policies comply with the facility's security requirements. In addition, FCM will ensure that its employees and subcontractors adhere to the Department of Correction's security and clearance procedures.

FCM completes an inventory of all needles, syringes, and surgical blades each working day. An ongoing inventory of all tools and instruments in use is conducted each working day and a master inventory is maintained. A log recording all completed inventories is maintained. When not in use, all needles, syringes, and surgical blades are kept under maximum security storage. The procedure includes:

- Daily entries in the medical sharps usage log detailing inventory of medical sharps
- Daily entries in the daily dental sharps usage log detailing inventory of dental sharps
- Addition of new supplies when received
- An ongoing instrument count sheet maintained daily
- Master inventory of all instruments
- Monthly inventory and cross check with the master inventory and noting additions, deletions, and other changes

FCM strictly adheres to requirements of the NCCHC, Drug Enforcement Administration (DEA), and applicable laws and statutes regarding proper accounting of medications. FCM policy A-24 describes all aspects of pharmaceuticals including the required inventory at the end of each shift of all DEA scheduled drugs. The inventory is undertaken by the off-going on on-coming staff. The off-going nurses may not leave the facility until the count is accurate or any inaccuracy is reported to the health services administrator. Staff must notify the FCM chief executive officer in writing of any discrepancy in excess of three dosage units. In addition to inventories each shift, DEA scheduled drugs are jointly inventoried at least quarterly by FCM's pharmacist and the health services administrator. Inventory records are maintained separately from those of non-controlled drugs and records show specifically who received each dosage unit.

6. Infectious Waste

FCM policy CID 2.0 details guidelines for safe handling, storage, and disposal of hazardous waste and infectious materials. FCM will work with facility at each to coordinate services. The policy clearly defines hazardous materials, then discusses the procedures staff are to carry out, including:

- Placement of waste including sharps
- Placement in a holding area
- Placement of a bag in a second bag as needed
- Affixing warning labels to containers, refrigerators, or other containers
- Notifying the vendor to collect the waste
- Maintenance of document of disposal for three years
- Training of all staff in the procedures.

7. Infection Control

FCM has developed and maintains a several hundred page *Infection Control Manual.* Major divisions include: infection control program, infection control committee, bloodborne pathogen exposure control plan, tuberculosis exposure control plan, tuberculosis skin test and interpretation, employee tuberculosis testing, standard precautions, isolation procedures, hand washing, medical supply decontamination, disposal of sharps and syringes, medical waste management, personal protective equipment, spill kits, and reportable diseases. The manual is updated regularly. FCM's policy manual addresses infectious disease education. All of these documents are in compliance with ACA and NCCHC standards. FCM will coordinate with the appropriate department of health in any revisions to its policies, procedures, and manuals as they relate to communicable diseases.

8. Inspections (Safety And Sanitary Inspection Procedures)

FCM will cooperate fully in all required safety and sanitary inspections. These include inspections by fire officials, the Department of Correction, Division of Public Health inspectors, building officials, and any local, state, or other officials. Of course, inspectors would first be cleared through proper security procedures. FCM will ensure that its work areas, equipment, and supplies are kept secure, safe, and sanitary.

FCM's health services administrator will ensure that staff conduct a formal inspection of all areas at least monthly, with follow-up inspections to assure that correction has been taken. Staff will prepare written reports with copies sent to the warden's office. FCM will include these findings as a regular agenda item at the regular Medical Administrative Committee meeting.

9. Disaster Plan

Immediately upon notification of contract award, FCM's transition team will begin the development of a disaster plan for each of the facilities. The plan will be completed within thirty days of the start date of the contract and submitted to the Deputy Bureau Chief of Management Services and the wardens or designees of each facility. Each plan will be carefully coordinated with the existing security plans and incorporated into the overall emergency plan.

Description of disaster plan for Delaware

FCM policy A-18 discusses medical disaster plans and calls for a written emergency and disaster preparedness plan to address internal and external emergency situations. The plan, entitled, *Health Services Medical Disaster Preparedness Plan,* is kept in a separate binder in each medical unit and each warden's office. Main divisions include:

- Training
- Coordination with local agencies
- Principles of action
- Initial response
- Notification of outside resources
- Triage areas
- Designated morgue
- Secondary triage area
- Disaster debriefing and resolution
- Lockdown situations
- Updating staff telephone numbers
- Facility maps and triage areas
- Location of facility disaster supplies
- Triage protocols
- Assignment of health care staff
- Allocation of additional non-facility staff if needed

In an emergency in Delaware, the available staff pool will include off duty staff from the Delaware corporate office, staff from the other health units of the facilities operated by the Department of Correction. FCM will revise its plan to incorporate components outlined in the request for proposals. As indicated in the orientation section of this proposal, emergency and disaster training is included as part of each employee's orientation. It will also be incorporated into the ongoing training program of FCM.

10. Inmate Workers

Per FCM policy and NCCHC standards, inmates are prohibited from being used as workers in the delivery of health care. This includes performing direct patient care, scheduling health care appointments, determining access to other inmates to health care services, having access to medical equipment or supplies, and operating diagnostic or therapeutic equipment. Under certain circumstances, inmate workers may provide janitorial or maintenance services in health services areas. FCM policy A-10 details prohibitions, work assignments, and supervision.

Inmate workers will be under the direct visual supervision of a security staff member at all times while working within the health services unit. Health services staff will monitor the workers' performance and will advise correctional staff of any inmate worker problems. Ultimately, the health services administrator is responsible for monitoring such activities but may delegate

monitoring and providing information to the Department of Correction regarding problems with inmate workers.

G. Records and Data Management

1. Protection and Storage

Policies and procedures for protecting patient confidentiality

The principle of confidentiality protects patients from disclosure of certain confidences entrusted to clinicians during a course of treatment. FCM embraces the philosophy of this principle and, in compliance with NCCHC and ACA standards, extends this to the inmates-patients and their clinicians. Some exceptions do exist such as reporting of certain alcohol and drug abuse, specific communicable diseases, and child abuse.

FCM strictly adheres to the confidentiality of all inmate records and will honor all Department of Correction's policies and procedures for safeguarding the confidentiality of such data. FCM policy A-20 discusses in detail confidentiality of inmates' health records. Discussion of confidentiality is also an important part of the new employee orientation. Attachment 4 is FCM's policy A-20.

Policies and procedures for protecting data

All active health records are maintained separately from the confinement case record. Medical personnel share with correctional staff only such information that has a potential impact on classification and institutional security and that which impacts the inmate's ability to participate in programs or other facility activities deemed necessary. The health services administrator controls access to the medical records. A copy of communications made for classification or institutional security purposes will be filed in the medical record. In addition, FCM understands the data confidentiality information presented in the request for proposals and will abide by its directives.

Maintenance and storage of records

Inactive records will be retained as permanent records in compliance with Delaware law. Immediately upon notification of contract award, FCM will research the state's requirements for maintenance and storage of records. Staff will modify its existing policy A-20 to incorporate the requirements. The policy addresses the number of years records are maintained, specific state location for storage, and process for archiving records.

Ensuring and monitoring accuracy

FCM is adamant in producing and maintaining accuracy. Policy A-20 details all aspects of the process. Only qualified medical personnel or medical services clerical staff collect and record data in medical records. All findings are recorded at the time of service delivery or not later than seven days from the time of discharge of the patient or termination of treatment. Ultimately the health services administrator has responsibility for the accuracy of medical records.

Linking to the electronic data collection system of the Department of Correction

As outlined below, FCM employs its own programmers and information systems staff. In addition to routine program and system maintenance, these individuals are responsible for updating and

modifying existing software to meet new standards or state-specific reporting requirements. They are also responsible for providing training and program support to staff. This group of individuals, along with appropriate management staff also will work with the Department of Correction in linking to the electronic data collection system of the Department of Correction.

2. Record Content

FCM maintains a confidential medical record for each inmate to provide accurate, chronological documentation of inpatient and outpatient medical, dental. and psychological care rendered during the period of incarceration. Records comply with all state and federal statutes and national medical and correctional standards.

Inmate medical records will be maintained in the health care unit. The FCM health services administrator oversees the operations of this area. The medical records clerk reports directly to the health services administrator. FCM uses a problem oriented medical record format. The system is in compliance with NCCHC and ACA Standards.

Each medical record must be complete, filed promptly, and most importantly, contain accurate, legible entries. Since this record may be the only source of accurate medical information available, FCM personnel will assure the completeness, accuracy, and accessibility of this document. Medical record audits for completeness will be done on a regular basis under the supervision of the health services administrator. The medical records staff will perform the following medical records-related duties:

- File all reports and notes in the medical record quickly and accurately
- Schedule patients for clinics
- Assist with the medical audit process
- Collect and maintain statistical data
- Assist with the quality assurance program
- Assist in conducting chart audits
- Retrieve, store, and transfer medical records in a timely manner
- Educate other health care staff in the use of the specific chart forms to be used, including a problem list and proper format for charting

<u>Contents of patient medical record</u>

Following the New Health Insurance Portability Accountability Act (HIPAA) guideline for confidentiality of the medical record, and in compliance with FCM policy A-20, FCM's medical records will contain:

- Problem information
- Complete inmate screening documents (medical, dental, and mental health)
- Health appraisal forms (history and physical)
- Physicians' order sheets
- All findings, diagnoses, treatments, and dispositions
- Record of prescribed medications and their administration

- Record of laboratory, x-ray, and diagnostic studies ordered and the results
- Signatures and titles of persons making entries
- Health services encounters such as pre-segregation evaluations, service referral requests, and nursing care protocols
- Health services reports such as dental and mental health consultations
- Treatment plans
- Progress reports
- Transfer forms
- Discharge summaries of inpatient hospitalizations and other termination summaries
- Consent or refusal forms when appropriate for specific cases
- Release of information forms when appropriate for specific cases
- Medical records from previous incarcerations of recommitment, if available
- Miscellaneous correspondence and medical pass copies.

Updating medical records

The loose filing is managed by the medical record clerks. Only qualified medical personnel or medical services clerical staff collect and record date in the medical record.

Use of ICD-9 codes (and level of specificity) in automated medical record system or capturing medical diagnoses

Use of the International Classification of Disease – 9th Revision (ICD-9 codes) ensures proper assignment of diagnosis codes, such as age, sex, and primary diagnosis flags. Coding assignment is completed at the corporate level only for outpatient services. FCM collects the three digit with two digit decimal modifier, such as 289.59.

Entering CPT-4 codes (and level of specificity) and capturing of medical provider services

CPT codes define procedures preformed by physicians or other health care provides. Procedures can be sorted in a database by CPT codes. FCM collects the five-digit and hyphen two digit modifier, such as 88312-26

Entering DSM-IV with axis codes (and level of specificity) and capturing of mental health services

All diagnoses will be documented using the DSM-IV axis system of identification. Depending on length of present incarceration, Axis IV (psychosocial and environmental problems) may or may not be addressed on a case-by-case basis. Fifth digit coding on axis I and II will not be done for specifiers but will be noted for subtypes of a disorder where applicable.

Allowing on-line access of medical record data to Department of Correction

AT this time, FCM facilities cannot access the billing system at the FCM corporate office. However pertinent information can be down-loaded and e-mailed to the facility site, as requested. FCM will work with staff of the Department of Correction with regard to the level and fee (if any) for such information. Until FCM's information systems staff have an opportunity to thoroughly investigate

the systems of the Department of Correction, FCM is hesitant to confirm the ability to provide the Department of Correction access to all data elements (monthly paid services, eligibility information, diagnosis and service codes, and identity of providers) as well as integration and reporting each service to provide comprehensive utilization profiles for each inpatient stay. In addition, FCM and the Department of Correction will need to explore the allowable levels of exchanging specific inmate information. FCM recommends an immediate meeting of the information staff from both organizations as soon as possible to establish a concrete plan.

Elements from hospital bill (UB-92) and retrievable information for reports

The hospital detailed bill is defined by the specific hospital material management and billing system. There are key elements that are generic to most systems. Regardless of the format, the final hospitals bill are reported on the UB-92 form.

There are eighty-five data input fields on the UB-92, including:

- Hospital provider demographics such as name, address, federal tax identification number
- Inmate demographics such as name, identification number, address
- Inclusive dates of service
- Hospital revenue codes with the associated descriptions, total charges, and HCPCS rates (room charges)
- Payor demographics including name, address, and identification number
- Procedure codes, diagnosis codes
- Attending physician's identifying information
- Name of hospital representative preparing the form

Elements from medical provider bill (CMS-1500)

The HCFA 1500 (now referred to as the CMS-1500) form is generated by providers for services rendered to the inmate while hospitalized. There are thirty-three data input fields including:

- Inmate demographics including name, identification number, address, and date of birth
- Insurance information
- Authorization signature and date
- Workers' compensation information
- Name of referring physician and identification number
- Diagnosis code(s)
- Related services date(s)
- Dates services rendered, associated CPT codes, and associated charges.
- Total charges and outstanding balance, if applicable
- Name and address of facility where services were rendered

3. Management Information System

FCM has worked with multiple correctional inmate data base systems. Coupled with internal development data spreadsheets, this has given FCM insight into the essential components on both a fully integrated inmate medical data systems and a warehouse.

After nearly three years in development and design, FCM has developed a proprietary data management software package. The Inmate Medical Manager is a networked Windows-based system that uses standard Microsoft security encryption. The program was designed to schedule and track inmate medical, mental health, and dental services. It has the ability to integrate with the facility's inmate management system to capture basic inmate demographics such as name, identification number, sex, and date of entry into the system. This eliminates transcription errors and reduces employees' time for redundant information entry. By the use of administrative passwords, the integrity and confidentiality of the systems are protected and monitored.

The system produces both routine or "ad hoc: reports. The system generates reports to indicate when an inmate needs to receive a particular service based on NCCHC standards such as inmates requiring PPD reads or inmates due for routine physical examinations. The system can also generate reports of appointments for all services including routine physicals, chronic care clinics, mental health screens, mental health visits, dental services, follow up appointments, treatment appointments, urgent appointments, etc.

Rather than simply producing spreadsheets that schedule and track separate appointments, the system aligns all activity to the specific inmate. The system builds a medical service chronological event summary for each inmate, regardless of the number of services provided. The chronological event summary is invaluable to health services providers in responding to inmate grievances or to requests from other providers.

In addition, the system manages providers' daily schedules and tracks the status of inmates' requests for all services. It also tracks pharmacy, provides for point-of-care medication administration, and documentation. Medication administration records (MARs) are electronically maintained and chart hard copies are printed.

The software produces a variety of compliance reports to ensure that all care is delivered in accordance with ACA, JCAHO, NCCHC, and state-specific standards. FCM has the capability to modify its existing program to meet the needs of various state and facility reporting and compliance standards.

FCM employs its own programmers and information systems staff. In addition to routine program and system maintenance, these individuals are responsible for updating and modifying existing software to meet new standards or state-specific reporting requirements. They are also responsible for providing training and program support to staff. This group of individuals, along with appropriate management staff, will coordinate closely with the Department of Correction to ensure meeting the reporting requirements. As necessary, FCM will hire consultants both to produce appropriate software and provide training.

As discussed throughout this proposal, FCM had limited opportunities to meet with staff of the Department of Correction to discuss details of operations and services. Therefore, at this time, offering a detailed plan for management information systems is impossible. FCM is at a competitive disadvantage because of limited information. On the other hand, FCM will be able to explore the current system and work closely with the Department of Correction and the Office of Information Services in the implementation of the Delaware Automated Correction System and other management information systems. FCM will meet immediately with the appropriate staff as soon as possible after notification of contract award to prepare a detailed plan for management information systems.

H. Staff, Staffing Patterns, and Training

1. Staffing Pattern

At the end of this sub-section H1, staffing patterns, are staffing patterns for each of the institutions. They include staffing levels, numbers, and times by position (days, evenings, nights, weekends). The patterns also indicate the full-time equivalents (FTEs) and system-wide management staff needed to manage the contract. The organization charts included as attachment 3 delineates lines of authority.

Ratio of inmates/patients to staff including types of staff and institutional differences

Table 5 below indicates the staff to inmate ratio. The table lists facilities separately. The administrative staff includes the health services administrator and the RN supervisors. The direct service staff includes certified nursing assistants, nurse practitioners, physician assistants, medical records clerks, pharmacy technicians, x-ray technicians, dental assistants, dentists, psychologists, psychiatrists, mental health clinicians, and dieticians.

Table 5. Medical staff to inmate ratio

Facility	Total direct staff	Inmate count	Ratio	MDs	RNs	LPNs	Admin staff	Direct service staff
Lake Erie Correctional Institution	30	1380	1:46	1	15	0	2	12
North Coast Correctional Treatment Facility	24	552	1:23	1	12	0	2	9
Central North Correctional Centre	35	1152	1:32	1	13	10	2	9
Pima County Adult Detention Center	50	1500	1:30	1	16	11	4	18

Covering periods of employee absences and relief factors included

FCM will develop and maintain a float pool of professional staff. These employees will receive the same level and length of medical and security training as full-time and part-time employees and will serve on-call to fill staffing needs arising from vacations, illnesses, or family leave absences.

In the event that pool personnel cannot cover absences, FCM has an established procedure to insure that salaried staff members (health service administrators, nursing supervisors, and so forth) are available to provide coverage. If necessary, employees from other facilities will be assigned to temporary duty in the affected location. Although FCM does not, as a rule, use staffing agencies,

the human resources department will identify available services for catastrophic emergencies, such as influenza epidemics.

The staffing plans included in this proposal are based on the following relief factors:

- 1.2 for staff working eight hour shifts five days per week
- 1.60 for staff working eight hour shifts seven days per week
- 1.72 for staff working twelve hour shifts five days per week
- 2.6 for staff working twelve hour shifts seven days per week

Recruitment plan including salary ranges and benefits

To ensure a sufficient number of qualified employees, FCM will recruit from many resources, using a flexible staffing plan. The plan gives preference to current medical service employees working in the facilities. Of course, FCM will expect all staff to conform to the policies, procedures, and other requirements of FCM, including the initial 120 day probation period.

FCM's goal is to deliver the best medical services possible while remaining cost-effective. Each employee contributes directly to meeting this goal. FCM focuses on continual training to allow employees the opportunity to advance within the company. As employees are FCM's most precious resource, FCM encourages open communication through prescheduled staff meetings and open door policies.

One of the most effective ways to recruit new staff is asking current employees to refer qualified acquaintances. FCM provides various incentives to the referring employee if the referred individual is hired and successfully completes the probationary period.

FCM has extensive experience in developing contacts among medical educators, both in universities and vocational schools. These contacts provide leads on alumni and promising graduates.

Other recruitment sources and tools include:

- Internal promotions
- Internal transfers
- Newspaper advertising
- Internet job postings and résumé banks
- Walk-in applicants
- Job fairs
- State employment services

Upon notification of contract award, human resources staff will initiate appropriate recruitment actions including posting the vacancy in accordance with the internal job bidding system, reviewing applications already on file, notifying community and employment agencies, encouraging employee referrals, and advertising locally and nationally as needed.

The human resources department and the selecting supervisor will jointly review and interview applicants to identify those who have the combination of experience, professional and interpersonal skills, and education that most closely fit the requirements of the position.

As necessary, corporate human resource staff will travel to Delaware to recruit, interview, and orient employees. In fact, the human resources manager will be part of the transition team that will work from FCM's Delaware office for three to six months, as needed. Corporate staff will also work closely with health service administrators and systems coordinators at each facility. FCM will provide full support in implementing and maintaining processes necessary to recruit and retain a full complement of medical personnel.

FCM conducts salary surveys and adjusts salaries to reflect market trends. This encourages employees to join and remain with FCM. Annually, each employee's performance is reviewed using the team approach. Historically, FCM awards employees 3 percent to 5 percent merit raises annually. A comprehensive benefit plan, discussed below, also assists in recruiting and retaining employees.

Names, résumés, and letters of intent for potential staff and providers

As detailed in this section, FCM fully intends to maintain as many staff as possible from the facilities. Several existing management staff of FCM are seriously considering the opportunity to assume positions in the facilities. In compliance with the request for proposals, FCM will provide within thirty days of contract signing the names, résumés, or letters of intent for all of its potential health services administrators, medical director, dentists, psychiatrists, chief psychologist, and providers of on-site specialty services by institution.

For at least three to six months, a team of the company's top staff will be on-site setting up services. Their résumés are included as attachment 15. These include:

Norma J. Peal, Ph.D., director of development
Renee Manda, R.N., M.S, director of clinical services
Ralph Tate, health services administrator at North Coast Correctional Treatment Facility
Todd Johnson, systems coordinator, Pima County Adult Detention Center

In addition, the following staff will be at the facilities extensively during this period and frequently thereafter:

Tammy Y. Kastre, M.D., chief executive officer
Mike Johnson, director of operations
Glenda Crabbe, R.N., nurse educator
Heeten Desai, M.D., FCM medical director
Linda Corbin, M.P.A., human resource manager

Also included is a résumé for Valerie Tennessen who will work closely with the director of clinical services in all areas related to accreditation and policy and procedures modification.

Name and title of person with overall responsibility for administrative services

Norma J. Peal, Ph.D. will have overall responsibility for administrative services. During at least the initial three to six months, this person will devote 75 percent of work time to the Delaware facilities.

List of positions and job descriptions (including numbers for each facility) including back-up staff

The list of positions are included in the staffing pattern for each facility at the end of this sub section. Comprehensive job descriptions for each position are included as attachment 16.

Retention program and turnover ratio

As evidenced by FCM's success with prior contracts, staff have developed excellent systems for improving employee retention rates. These include the selection process, cross-training opportunities, ability to transfer throughout the company, and excellent wage and benefit packages.

The retention of staff starts with staff selection and the interview process. The best predictor of future behavior is recent and relevant past behavior. The interview team prepares for each interview by:

- Comprehending the mission, vision, and values of FCM
- Knowing the job requirements
- Reviewing the application and résumé (if applicable)
- Preparing relevant and realistic job-related questions

By the implementation of a logical and objective selection process, FCM minimizes turnover, increases productivity, decreases unproductive behavior, and relieves personnel stress.

Other factors identified as important by employees in facilities include the opportunity to receive cross training and the variety of work. These allow breadth and depth of skill development and enhance their sense of participation in a health care team. FCM's structured preceptorship and direct interaction with the corporate nursing educator are especially helpful for those new to correctional medicine.

FCM's data show that if an employee stays in a position more than nine months, the employee is satisfied with the job. The most recent employee satisfaction survey confirmed key reasons employees chose to stay in their present positions:

- FCM's educational programs and training
- The opportunity to transfer within the company
- Recognition of exceptional performance, based on peer recommendations and rewarded with gift certificates
- Employee of the month program

FCM conducts salary surveys and adjusts wages to reflect localized market trends. This encourages employees to join and remain with FCM. In addition, each employee's performance is

reviewed annually using the team approach. Historically, FCM awards employees 3 percent to 5 percent merit raises each year.

FCM has an excellent retention record for medical directors and health services administrators. There has been only one turnover at this level. The health services administrator of one facility was moved to a newly opened facility and the vacant position was filled by internal promotion.

Recent data indicate the following turnover ratios:

First Correctional Medical Corporate	9 percent
Central Arizona Detention Center	7 percent
Florence Correctional Center	11 percent
Central North Correctional Centre	In ramp-up status; start date November 2001
Pima County Adult Detention Center	In initial start-up status; start date March 2002

These turnover rates are well below those experienced by other organizations, as reported in a recent study. In fact, the national average for turnover is approximately 15 percent. (William M. Mercer, Inc., *Attracting and Retaining Registered Nurses.* December 2000).

Following is turnover ratio by contract by position. Only aggregate figures are available for closed contracts. FCM is currently in the start-up or ramp-up phase for Central North Correctional Center (Penetanguishene, Ontario, Canada) and Pima County Adult Detention Center (Tucson, Arizona).

Table 6. Lake Erie Correctional Institution 2001 turnover ratio rates

Position	Turnover Ratio
Health services administrator	No turnover
Registered nurse	12.5%
Medical records clerk	14%
Physician/medical director	No turnover
Psychiatrist–MD	No turnover
Dentist	No turnover
Dental assistant	No turnover
Psychiatric nurse	No turnover
Psychologist	No turnover
Licensed independent social worker	No turnover

Table 7. North Coast Correctional Training Facility 2001 turnover ratio rates

Position	Turnover Ratio
Health services administrator	No turnover
Director of nursing	No turnover
Registered nurse	No turnover after transition period
Registered nurse–psychiatric	No turnover

Medical records clerk	No turnover after transition period
Psychology clerk	No turnover
Physician–clinical director	No turnover
Psychiatrist–MD	No turnover
Psychologist	No turnover
Dentist	No turnover
Dental hygienist	No turnover
Dental assistant	No turnover
Registered dietetic technician	No turnover

Staffing patterns for projected expansions

The staffing plans presented in this proposal are appropriate to meet the levels of inmates outlined in the demographic information presented by the Department of Correction and during the site visits. The staff is sufficient for fluctuations in inmate counts. If a facility expands significantly or if a facility or unit is added, FCM would need to increase staffing in accordance with NCCHC standards, the standards that FCM has used throughout this proposal to determine staffing levels.

Past problems and resolutions with staffing

FCM's primary staffing difficulties have been almost exclusively attributable to the remote locations of prison facilities where the company has operated medical services. For example, one facility was approximately one hour's driving distance from a populated area. Another is located approximately forty-five minutes from the nearest labor pool in a region frequently buffeted by snow.

Generally, FCM provides relocation assistance to physicians, dentists, and mental health professionals in geographic areas where vacancies for specialists are difficult to fill. Contract stipulations ensure that these personnel remain at the facility for a substantial period in return for relocation assistance.

Nursing professionals and other health care staff are generally paid at or above the prevailing wage level for the area. In addition the company's comprehensive benefits package is an important factor in recruiting and retaining staff. FCM's commitment to a team approach to health care also draws talent, so that staffing issues are generally resolved by the end of the transition period.

Depending on location and the labor pool, FCM also uses creative solutions, such as encouraging car pools, arranging flexible scheduling, and incentive plans.

Documentation to validate information

FCM's references provided above can verify FCM's handling of all areas related to staffing.

DELAWARE CORRECTIONAL CENTER
Staffing Pattern for Delaware RFP 2828

Administrative Staff

Position	# of staff	Hr/Day	Shift	Day/Wk	relief factor	F.T.E.s
Health Service Admin.(R.N.)	1	8	8a-5p	5	1.0	1.0
Nursing Supervisor	1	16	7a-11p	5	1.0	2.0
CID Nurse (R.N.)	1	8	8a-5p	5	1.0	1.0
System Coordinator*	1	8	8a-5p	5	1.0	1.0
QA Nurse (R.N.)	1	8	8a-5p	5	1.0	1.0
Pharmacist	1	8	8a-5p	5	1.0	1.0
				Sub Total		7.0

*This position is funded by FCMI's G & A and serves directly under the Director of Operations at the facility

Central Medical Staff

Position	Shift	Sun.	Mon.	Tues.	Weds.	Thurs.	Friday	Sat.	relief factor	F.T.E.s
R.N.	7a-7p	2	2	2	2	2	2	2	2.5	5.0
R.N.	7p-7a	2	2	2	2	2	2	2	2.5	5.0
R.N.	8a-4p	0	1	1	1	1	1	0	1.2	1.2
R.N.	8a-4p	1	1	1	1	1	1	1	1.6	1.6
L.P.N.	7a-7p	2	2	2	2	2	2	2	2.5	5.0
L.P.N. (1)	6a-10p	6	6	6	6	6	6	6	1.6	19.2
L.P.N.	7p-7a	2	2	2	2	2	2	2	2.5	5.0
Pharmacy Tech.	7a-3p	0	1	1	1	1	1	0	1.0	1.0
Radiology Tech.	8a-4p	0	1	1	1	1	1	0	1.0	1.0
Cert. Nursing Assistant	8a-4p	1	2	2	2	2	2	1	1.2/1.6	2.8
Clerk (Med Rec)	7a-3p	1	2	2	2	2	2	1	1.2/1.6	2.8
Clerk (Med Rec)	3p-11p	1	2	2	2	2	2	1	1.2/1.6	2.8
Midlevel Provider	7a-3p	1	1	1	1	1	1	1	1.6	1.6
Midlevel Provider	8a-5p	0	1	1	1	1	1	0	1.2	1.2
Physician/Medical Director	8a-4p	0	1	1	1	1	1	0	1.0	1.0
Dentist	8a-4p	0	2	2	2	2	2	0	1.0	2.0
Dental Assistant	8a-6p	0	2	2	2	2	2	2	0.0	2.0
								Sub Total		60.2

Dietician?

1.) Primary duties are medication delivery, three times per day for all appropriate housing pods.

Mental Health Staff

Position	Shift	Sun.	Mon.	Tues.	Weds.	Thurs.	Friday	Sat.	relief factor	F.T.E.s
Psychologist (PhD or EdD)	8a-5p	0	1	1	1	1	1	0	1.0	1.0
Mental Health Clinician	8a-5p	1	0	1	1	1	1	0	1.0	1.0
Mental Health Clinician	5p-2a	0	1	1	1	1	0	1	1.0	1.0
Psychiatric Nurse (R.N.)	8a-4p	0	1	1	1	1	1	0	1.0	1.0
Psychiatrist	8a-2p	0	1	1	1	1	1	0	1.0	0.75
								Sub Total		4.8

MORRIS CORRECTIONAL CENTER
Staffing Pattern for Delaware RFP 2828

Administrative Staff

Position	# of staff	Hr/Day	Shift	Day/Wk	relief factor	F.T.E.s
Health Service Admin. (R.N.)	0	0	0	0	0.0	0**
				Subtotal Staff		0.0

** Please see below: the dayshift RN will be the acting health services administrator with backup available via the Delaware Corporate office and the Gander Hill administrative staff.

Core Staffing Pattern

Position	Shift	Sun.	Mon.	Tues.	Weds.	Thurs.	Friday	Sat.	relief factor	total F.T.E.s
R.N.	7a-3p	1	1	1	1	1	1	1	1.6	1.60
L.P.N.	3p-11p	1	1	1	1	1	1	1	1.6	1.60
Clerk (Med Rec)	8a-12n	0	1	1	1	1	1	0	1.0	0.50
Mental Health Clinician	8a-12n	0	0	0	0	1	0	0	1.0	0.10
Psychiatrist	8a-12n	0	0	1	0	0	0	0	1.0	0.10
Physician/Medical Director	8a-11a	0	1	0	1	0	0	0	1.0	0.15
								Subtotal Staff		4.05

7Am - 11pm coverage
7 days/wk
Clerk 5 days/wk
1/2 days

MULTI-PURPOSE CRIMINAL JUSTICE FACILITY (GANDER HILL)
Staffing Pattern for Delaware RFP 2828

Administrative Staff

Position	# of staff	Hr/Day	Shift	Day/Wk	relief factor	F.T.E.s
Health Service Admin.(R.N.)	1	8	8a-5p	5	1.0	1.0
Nursing Supervisor	1	16	7a-11p	5	1.0	2.0
MIS Manager	1	8	8a-5p	5	1.0	1.0
CID Nurse (R.N.)	1	8	8a-5p	5	1.0	1.0
System Coordinator*	1	8	8a-5p	5	1.0	1.0
QA Nurse (R.N.)	1	8	8a-5p	5	1.0	1.0
				Sub Total		7.0

*This position is funded by FCMI's G & A and serves directly under the Director of Operations at the facility

Central Medical Staff

Position	Shift	Sun.	Mon.	Tues.	Weds.	Thurs.	Friday	Sat.	relief factor	F.T.E.s
R.N.	7a-7p	2	2	2	2	2	2	2	2.5	5.0
R.N.	7p-7a	2	2	2	2	2	2	2	2.5	5.0
R.N.	8a-4p	1	1	1	1	1	1	1	1.6	1.6
L.P.N.	~~7a-7p~~	2	2	2	2	2	2	2	2.5	5.0
L.P.N. (1)	6a-10p	4	4	4	4	4	4	4	1.6	12.8
L.P.N.	7p-7a	1	1	1	1	1	1	1	2.5	2.5
Radiology Tech.	8a-1p	0	1	1	0	1	1	0	1.0	0.5
Cert. Nursing Assistant	8a-4p	1	2	2	2	2	2	1	1.2/1.6	2.8
Clerk (Med Rec)	7a-3p	1	2	2	2	2	2	1	1.2/1.6	2.8
Clerk (Med Rec)	3p-11p	0	1	1	1	1	1	0	1.2	1.2
Midlevel Provider	7a-3p	1	1	0	1	0	1	1	1.0	1.0
Midlevel Provider	8a-5p	0	1	1	1	1	1	0	1.0	1.0
Physician/Medical Director	8a-4p	0	1	1	1	1	1	0	1.0	1.0
Dentist	8a-4p	0	1	1	1	1	1	0	1.0	1.0
Dental Assistant	8a-6p	0	1	1	1	1	1	0	1.0	1.0
								Sub Total		44.2

Dietician?

1.) Primary duties are medication delivery, three times per day for all appropriate housing pods.

What is the real shift? 8 bodies w/ relief factor?

Mental Health Staff

Position	Shift	Sun.	Mon.	Tues.	Weds.	Thurs.	Friday	Sat.	relief factor	F.T.E.s
Psychologist (PhD or EdD)	8a-5p	0	1	1	1	1	1	0	1.0	1.0
Mental Health Clinician	8a-5p	[redacted]	1	0	1	1	1	0	1.0	1.0
Mental Health Clinician	5p-2a	0	1	1	1	0	1	[redacted]	1.0	1.0
Psychiatric Nurse (R.N.)	8a-4p	0	1	1	1	1	1	0	1.0	1.0
Psychiatrist	8a-2p	0	1	1	1	1	1	0	1.0	0.75
								Sub Total		4.8

DELO[illegible] J. BAYLOR WOMEN'S CORRECTIONAL INSTITUTION
Staffing Pattern for Delaware RFP No. 2828

7a-5p

Administrative Staff

Position	# of staff	Hr/Day	Shift	Day/Wk	relief factor	F.T.E.s
Health Service Admin.	1	8	8a-5p	5	1.0	1.0
Nursing Supervisor (R.N.)**	1	8	7a-4p	5	1.0	1.0
				Subtotal Staff		2.0

** This position will perform the duties of the Quality Assurance and Communicable and Infectious Disease Nurse.

Core Staffing Pattern

Position	Shift	Sun.	Mon.	Tues.	Weds.	Thurs.	Friday	Sat.	relief factor	total F.T.E.s
R.N.	7a-7p	1	1	1	1	1	1	1	2.6	2.6
R.N.	7p-7a	1	1	1	1	1	1	1	2.6	2.6
L.P.N.	7a-3p	0	1	1	1	1	1	0	1.2	1.2
L.P.N.	3p-11p	1	1	1	1	1	1	1	1.6	1.6
Psych. R.N.	7a-3p	0	1	1	1	1	1	0	1.0	1.0
Clerk (Med Rec)	7a-3p	0	1	1	1	1	1	0	1.2	1.2
Psychologist	8a-6p	0	1	0	0	1	0	0	1.0	0.5
Mental Health Clinician	8a-4p	0	1	1	1	1	1	0	1.0	1.0
Psychiatrist	8-12p	0	0	1	0	1	0	1	1.0	0.3
Physician/Medical Director	8a-12p	0	0	1	0	1	0	0	1.0	0.2
Mid-level Provider	8a-4p	0	1	0	1	0	1	0	1.0	0.6
Dentist	8a-2p	0	0	1	0	1	0	0	1.0	0.3
Dental Assistant	8a-2p	0	0	1	0	1	0	0	1.0	0.3
								Subtotal Staff		13.4

TOTAL - 15.4

Appears to be low
Are 12hr shifts really feasible

WEBB CORRECTIONAL CENTER
Staffing Pattern for Delaware RFP 2828

Administrative Staff

Position	# of staff	Hr/Day	Shift	Day/Wk	relief factor	F.T.E.s
Health Service Admin. (R.N.)	0	0	0	0	0.0	0**
				Subtotal Staff		0.0

** Please see below: the dayshift RN will be the acting Health Administrator with backup available via the Delaware Corporate office and the Gander Hill administrative staff.

Core Staffing Pattern

Position	Shift	Sun.	Mon.	Tues.	Weds.	Thurs.	Friday	Sat.	relief factor	total F.T.E.s
R.N.	7a-3p	1	1	1	1	1	1	1	1.6	1.60
L.P.N.	3p-11p	1	1	1	1	1	1	1	1.6	1.60
Clerk (Med Rec)	7a-12n	0	1	1	1	1	1	0	1.0	0.50
Mental Health Clinician	8a-12n	0	0	0	0	1	0	0	1.0	0.10
Psychiatrist	8a-12n	0	0	1	0	0	0	0	1.0	0.10
Physician/Medical Director	8a-11a	0	1	0	1	0	0	0	1.0	0.15
								Subtotal Staff		4.05

Need this staff to deliver psychotropics

7am-11pm 7 days/wk

CENTR[illegible] VIOLOATION OF PROBATION CENTER
Staffing Pattern for Delaware RFP 2828

Administrative Staff

Position	# of staff	Hr/Day	Shift	Day/Wk	relief factor	F.T.E.s
Health Service Admin. (R.N.)	1	8	8a-5p	5	1.0	1.0
				Subtotal Staff		1.0

Core Staffing Pattern

Position	Shift	Sun.	Mon.	Tues.	Weds.	Thurs.	Friday	Sat.	relief factor	total F.T.E.s
L.P.N.	7a-3p	1	1	1	1	1	1	1	1.6	1.60
R.N.	3p-11p	1	1	1	1	1	1	1	1.6	1.60
Clerk (Med Rec)	7a-3p	0	1	1	1	1	1	0	1.2	1.20
Mental Health Clinician	8a-4p	0	0	1	0	1	0	0	1.0	0.40
Psychiatrist	8a-12n	0	0	1	0	0	0	0	1.0	0.10
Physician/Medical Director	8a-12n	0	1	0	1	0	0	0	1.0	0.20
								Subtotal Staff		5.10

Dentist?

7am - 11pm
7days/wk

SUSSEX CORRECTIONAL INSTITUTION
Staffing Pattern for Delaware RFP 2828

Administrative Staff

Position	# of staff	Hr/Day	Shift	Day/Wk	relief factor	F.T.E.s
Health Service Admin.	1	8	8a-5p	5	1.0	1.0
Nursing Supervisor**	1	8	7a-4p	5	1.0	1.0
				Subtotal Staff		2.0

** This position will cover the job duties of Quality Assurance and Comminicable Infectious Disease nurse.

Core Staffing Pattern

Position	Shift	Sun.	Mon.	Tues.	Weds.	Thurs.	Friday	Sat.	relief factor	total F.T.E.s
R.N.	7a-7p	1	1	1	1	1	1	1	2.6	2.6
R.N.	7p-7a	1	1	1	1	1	1	1	2.6	2.6
L.P.N.	7a-7p	1	1	1	1	1	1	1	2.6	2.6
L.P.N.	7p-7a	1	1	1	1	1	1	1	2.6	2.6
R.N. Psych	7a-3p	0	1	1	1	1	1	0	1.2	1.2
R.N. Psych	3p-11p	0	1	1	1	1	1	0	1.2	1.2
Cert. Nursing Assist.	7a-3p	0	1	1	1	1	1	0	1.0	1.0
Clerk (Med Rec)	7a-3p	0	2	2	2	2	2	0	1.2	2.4
Mental Health Clinician	8a-4p	0	1	1	1	1	1	0	1.0	1.0
Psychologist	8a-5p	0	1	1	1	1	1	0	1.0	1.0
Psychiatrist	8a-2p	0	1	0	1	0	1	0	1.0	0.4
Physician/Medical Director	8a-12p	0	1	0	0	1	0	0	1.0	0.2
Mid-level Provider	8a-4p	0	1	1	1	1	1	0	1.0	1.0
Dietician***	8a-5p	0	1	1	1	1	1	0	1.0	1.0
								Subtotal Staff		20.8

***This position will be shared for all facilities across the state, with the primary focus on those patients referred by the providers who are enrolled in chronic care clinic.

SUSSE.. COMMUNITY CORRECTIONS CENTER
Staffing Pattern for Delaware RFP 2828

Administrative Staff

Position	# of staff	Hr/Day	Shift	Day/Wk	relief factor	F.T.E.s
Health Service Admin. (R.N.)	1	8	8a-5p	5	1.0	1.0
				Subtotal Staff		1.0

24/7

Core Staffing Pattern

Position	Shift	Sun.	Mon.	Tues.	Weds.	Thurs.	Friday	Sat.	relief factor	total F.T.E.s
R.N.	7a-7p	1	1	1	1	1	1	1	2.6	2.6
R.N.	7p-7a	1	1	1	1	1	1	1	2.6	2.6
L.P.N.	7a-3p	1	1	1	1	1	1	1	1.6	1.6
L.P.N.	3p-11p	1	1	1	1	1	1	1	1.6	1.6
Clerk (Med Rec)	7a-3p	0	2	2	2	2	2	0	1.0	2.0
Mental Health Clinician	8a-4p	0	0	1	0	1	0	0	1.0	0.4
Psychiatrist	8a-12n	0	0	1	0	0	0	0	1.0	0.1
Physician/Medical Director	8a-12n	0	1	0	1	0	0	0	1.0	0.2
Mid-level Provider	8a-2p	0	0	1	0	1	0	1	1.0	0.45
								Subtotal Staff		11.55

PLUMA[illegible]X COMMUNITY CORRECTIONAL CENTER
Staffing Pattern for Delaware RFP 2828

Administrative Staff

Position	# of staff	Hr/Day	Shift	Day/Wk	relief factor	F.T.E.s
Health Service Admin. (R.N.)	0	0	0	0	0.0	0**
				Subtotal Staff		0.0

7Am-11pm 7 days/wk

** Please see below: the dayshift RN will be the acting Health Administrator with backup available via the Delaware Corporate FCM office and the Gander Hill administrative staff.

Core Staffing Pattern

Position	Shift	Sun.	Mon.	Tues.	Weds.	Thurs.	Friday	Sat.	relief factor	total F.T.E.s
R.N.	7a-3p	1	1	1	1	1	1	1	1.6	1.60
R.N.	3p-11p	1	1	1	1	1	1	1	1.6	1.60
Clerk (Med Rec)	7a-3p	0	1	1	1	1	1	0	1.2	1.20
Mental Health Clinician	8A-12n	0	0	1	0	1	0	0	1.0	0.20
Psychiatrist	8a-12n	0	0	1	0	0	0	0	1.0	0.10
Physician/Medical Director	8a-12n	0	1	0	1	0	0	0	1.0	0.20
								Subtotal Staff		4.90

2. Staff Certification and Licensing

FCM requires professional staff to maintain current licensure. Status of licenses and permits is monitored both by the health services administrator of individual facilities and by the corporate human resources department monthly. Corporate human resources personnel use a Microsoft Access database to track upcoming expiration dates for all licenses and certificates. FCM is thus able to ensure that licensed personnel remain in good standing with governing agencies.

If an employee's or independent contractor's license is terminated by the governing agency for cause, the employee or contractor will be terminated immediately. FCM's letters of intent and personnel policies specifically state that current licensure is a condition of continued employment.

Any employee who allows a license to lapse through negligence or non-renewal may be suspended without pay until the license is reinstated. If the employee shows evidence of having complied with renewal procedures in a timely manner, FCM will abide by the regulations of the governing agency regarding practice during the renewal process.

If an employee is placed on probationary status by the governing agency, the circumstances will be reviewed on a case-by-case basis by the medical director and disposed as ruled by the governing licensure agency and best medical practice.

3. Employee Benefits

Synopsis of employee benefits

The company's excellent benefit program, a key to recruiting and retaining high quality staff, includes:

- Flex plan medical and dental insurance
- Vision care program
- Employee assistance program
- Group term life and accidental death insurance plan
- Disability insurance
- Paid vacation and sick leave
- Paid holidays
- 401K retirement program
- Tuition reimbursement
- Payroll direct deposit
- Pre-tax premium plan
- Relocation assistance, if appropriate
- Hiring incentives

FCM's current health insurance plan is an Aetna open access health maintenance organization (HMO). One excellent feature of this plan is that there is no deductible. Primary care visits require a $15 co-pay; specialty visits require a $25 co-pay; and hospitalization requires a $500 co-pay.

The company's policy allows staff to provide immediate coverage for "spin-on" employees, or those currently working in facilities who choose to join FCM. Salaried employees are also eligible for immediate coverage. New employees become eligible for health coverage at completion of the 120 day probationary period.

FCM allows each employee $148 per month in a flexible spending account. Employees may use this account to offset the cost of health, dental, or vision premiums. Currently dental insurance is provided by Total Dental and vision is provided by Vision Service Plan (VSP). FCM is researching the cost that employees would have to pay in Delaware. The company's insurance expenses for employees in its Arizona corporate office are as follows per bi-weekly pay period (employees may distribute the $148 as they choose):

Table 8. Employee insurance cost

Coverage	Health Cost	Dental Cost	Vision Cost
Employee only	86.67	9.91	3.67
Employee plus spouse or other adult	201.50	20.73	7.89
Employee plus children	155.72	20.73	7.89
Employee plus family	246.96	32.79	7.89

Policies and procedures manual

Attachment 17 if FCM's employee handbook. All staff are required to read the manual and sign their understanding of it. Note that the request for proposals requested a copy of the "policies and procedures manual". That document is available for review for the Department of Correction. However, as the request is within the staffing section, FCM is including its employee manual.

4. Staff Orientation

Orientation for new employees

All FCM training and development addresses latest trends in ambulatory care and integrates custody and security driven practices. FCM provides a comprehensive pre-service orientation, on-the-job preceptorship, and periodic evaluations. Further, staff is offered monthly in-service training on topics relevant to correctional health care. Topics include communicable diseases, suicide signs and symptoms, chronic disease awareness, mental health illness, medical confidentiality, legal documentation, grief and loss, psychotropic medications, disaster preparedness, emergency care, and review of nursing assessment protocols.

FCM has prepared two orientation programs. One will be for existing staff who have been fully trained in correctional health care. Their orientation will center on policies, procedures, and processes of FCM. This orientation will satisfy the training standards required by NCCHC.

New staff will receive all training as required by NCCHC. In addition, each employee will be required to complete a forty hour preceptorship and a monitored orientation before assuming a shift assignment. At any time during the medical orientation, the health services administrator and the preceptor in collaboration may determine the need to extend the required orientation hours.

Because medical and correctional personnel are in frequent and close contact with inmates, they will receive special training from the mental health staff in the identification of individuals with possible emotional, mental, and developmental disorders. This training will include:

- Recognition of signs and symptoms of emotional disorders prevalent in inmate populations
- Recognition of signs of chemical dependency and symptoms of drug and alcohol intoxication and withdrawal
- Recognition of adverse reactions to psychotropic medication
- Recognition of signs of developmental disability, especially mental retardation
- Recognition of potential mental health emergencies and instruction in appropriate action in crisis situations
- Identification of medical problems of inmates housed in mental health units and proper referral for care
- Suicide prevention
- Instruction in procedures for referring an inmate to mental health staff for immediate evaluation
- First aid and cardiopulmonary resuscitation training

Pre-service orientation of new hires will include forty hours of security and medical practices training. FCM will co-ordinate with the Department of Correction's security staff to ensure their inclusion as a key element of orientation. FCM anticipates that the Department of Correction would provide approximately eight to sixteen hours of training to health services staff.

This entire orientation will be completed within the first thirty days of employment. In addition to extensive training on FCM philosophy, policies, procedures and forms, pre-service orientation will include the following:

- Department of Correction security practices (general and institution-specific)
- Security issues specific to medical services provision
- Department of Correction and FCM codes of ethics
- Code of conduct, including dress code and chains of command
- Drug free workplace policy and drug testing
- Blood borne pathogen policies
- Emergency procedures including FCM's disaster plan for each specific facility
- Facility tour (where permitted)

In addition to pre-service orientation, all FCM employees will be required to attend refresher training when offered by the Department of Correction.

All pre-service and refresher training will be documented in individual employee files and in the human resources training database. The Department of Correction, warden, Employee

Development Center, and Medical Review Committee will be notified of training completion. Notification will include the names of personnel trained, subject matter covered, date of training, and next training due date. Written documentation will be provided within thirty days (or earlier if required by the Department of Correction for clearance and identification card completion) after completion of training. Notification will be in the form of a memorandum and will be transmitted by U.S. Postal Service and electronic means to the designated contacts.

FCM also has a comprehensive training program for correctional officers that it could present–modified if requested–to employees of the Department of Correction. Topics are selected based on ACA and NCCHC standards, types of inmates, facility-specific concerns, and requested areas. Following is a synopsis of the base program.

CET

Module one–recognition of signs and symptoms, and knowledge of action required in potential emergencies

- Seizures
- High blood or low blood sugar reaction
- Chest pain
- Heat stroke and sun poisoning
- Alcohol and drug withdrawal
- Sports accidents or injuries including broken bones, and sprains

Module two–four minute emergency respond time

- Why four minutes? American Heart Association definition
- Emergency equipment such as automatic external defibrillators, oxygen, stretchers, "man down" bag

Module three–methods for obtaining assistance from the medical unit

- Radio calls
- Events description
- Types of assistance required–emergency, urgent, medical assistance

Module four–signs and symptoms of mental illness, mental retardation, and chemical dependency

- Level of consciousness
- Change in usual and customary behavior
- Attitude and attention span
- Physical assessment

Module five–first aid and cardiopulmonary resuscitation

- FCM reviews the guidelines but does not do instruction
- First responder responsibility review

- Use of personnel protective equipment
- First aid boxes–locations and process for restocking

Module six–inmate transfer to medical facility

- Emergency transfers
- What constitute an emergency call
- 911 call information required
- Correctional officer responsibility
- Medical staff responsibility
- Routine transfers
- What constitutes a routine transport
- Van vs. ambulance
- Correctional officer responsibility
- Medical staff responsibility
- Proper documentation guidelines and making appropriate progress notes
- Formatting of nursing protocols

Module seven–infectious disease

- Tuberculosis testing; importance of the timely (forty-eight to seventy-two hour) read
- Tuberculosis testing vs. Tuberculosis screening
- AIDS and HIV
- Hepatitis
- Clearance of inmates for kitchen work

Orientation curriculum and manuals

Attachment 18 is the agenda for the administrative orientation that all new employees attend.

Attachment 19 is the curriculum for orientation.

5. Facility Expansion and Growth

Opening a new facility or moving an infirmary (or other health services unit) to a new location requires the same factors as implementing a new contract. In general, the components are a detailed, facility specific plan; a transition team (with corporate and local staff); and a workable timeline. Perhaps the most important component is the establishment of an Interorganizational team to work on all of these components well before the change occurs.

For example, if the Department of Correction decided to open a new health services unit at the Multi-Purpose Criminal Justice Facility, FCM would expect to be a part of the interdisciplinary team from the very first meeting when the facility and services were discussed. Such a team would logically include participants such as security staff, financial advisors, construction and design staff, administrative staff of the Department of Correction, medical and administrative health services

staff, etc. Working within the guidelines and timelines of the interdisciplinary team, FCM would establish its own plans, timelines, and subcommittees.

I. Subcontracting

1. Selection

Selecting subcontractors

FCM selects its subcontractors based on a combination of factors including:

- Location of providers
- Cost
- Dependability
- Previous experience of FCM
- Recommendations
- Contract requirements
- Willingness to provide services on-site
- Timeliness of services

FCM monitors performance of its subcontractors based on the specific contract, the required experience and knowledge (see Table 9 below), and regulatory requirements (for example CLIA licenses maintenance for labs), and direct observation. Actions for non-performance vary greatly with activities ranging from a telephone call (for example, for a late delivery of soft goods) to legal action (such as malpractice by a medical specialty).

The following list is not meant to be comprehensive but only to provide a list of frequently required subcontractors. Although FCM intends to contract for statewide services as applicable and possible, other services will be facility specific.

Table 9. Commonly used subcontractors

Service	Description	Demonstrated knowledge And experience
Ambulance	Emergency response to facilities for life threatening emergencies; transport to hospital or other providers' locations for care	Ability to provide ALS, BLS, and 9-1-1 response Competitive prices Response time Geographic area covered * Required documents–b, f
Answering service–Contact One (current FCM vendor)	Single point of service for all emergency and provider after hours calls	Dependability Quality of service Nationwide availability Competitive prices * Required documents–f

Biohazardous waste–Steri Cycle (current FCM vendor)	Collection and disposal of biohazardous waste	Timeliness Safety record and quality of services Nationwide services Proper licensing * Required documents–b, f
Dental lab	Provision of dental appliances and prosthetics dental appliances, dental prostheses, and orthodontic devices	Ability to provide comprehensive services Timeliness of items Reasonable pricing Proper licenses * Required documents–b, f
Dental providers	Comprehensive dental services at all facilities with dental capabilities; may be only dentist or combination of dentist and other dental staff and specialists	Ability to provide services for time required Reasonable pricing Appropriate licenses and certifications Preference for small group with correctional experience * Required documents–a, b, c, e, f, g, h
Dialysis	Comprehensive on-site services for all facilities with dialysis beds; to include staff, filters, and other supplies	Ability to serve all facilities Appropriate licenses and certifications Documented experience Reasonable pricing Quality of service * Required documents–b, e, f, g, h
Eye glasses and other vision supplies–Orco Supplies (current FCM vendor)	Provision of eyeglasses and related items	Meets Medicare guidelines Provides glasses within seven days Reasonable pricing * Required documents–b, f
Hospitals–FCM contracts with local and specialty hospitals as possible	Comprehensive services, if possible, to include inpatient, outpatient, emergency, clinic, etc.	Accreditation and certifications Extent of services available Ability to provide convalescent and skilled nursing care Reputation in community Willingness to provide services on-site Reasonable pricing * Required documents–b, e, f, g, h
Laboratory–Sonora Quest Laboratory (current FCM vendor)	Analysis of specimens; providing supplies, centrifuge, dedicated printer; providing a certified specimen results	FCM's success with them Timeliness of results Accuracy of results Twenty-four hour availability * Required documents–b, f, g

Medical specialists	Variety of on-site and off-site medical specialists such as cardiologist, orthopedic surgeons, gynecologists, obstetricians, neurologists, ophthalmologists	Prefer as many from single group Ability to serve large area (statewide preferred) Proper licensing and credentialing Reasonable pricing Willingness to work on-site if appropriate * Required documents–a, b, c, d, e, f, g, h
Medical supplies–M.M.S. Medical Supplies (current FCM vendor)	Provide comprehensive array of medical soft goods and related supplies	Timeliness of delivery Accuracy of delivery Willingness to meet FCM's "just in time" and "par" requirements Competitive pricing Ability to provide for FCM facilities * Required documents
Optometry	Provide on-site vision examinations and routine eye care; order and fit eyeglasses	Willingness to work on-site Possession of portable equipment Reasonable pricing Proper licensing * Required documents–a, b, c, d, e, f, g, h
Oxygen and gauges–Ready Medi Health Care, Inc. (current FCM vendor)	Provide oxygen tanks and gauges on regular and as needed basis	Timeliness of service Ability to provide nationwide services Competitive prices * Required documents–b, f
Pager and cell phones	Provide pagers and cellular telephones for locally-based management staff	Quality of service and equipment Ability to serve entire geographic area Competitive price * Required documents
Professional services such as legal and financial–Joe May, CPA, and Martin Ryan, legal (current FCM subcontractors)	Provide accurate reporting, advise, etc., routinely and for special requests	Established relationship Timeliness and accuracy of work Accessibility * Required documents–b, f
Radiation monitors–ICN Worldwide Dosimetry Service (current FCM vendor)	Monitoring of levels of radiation staff in contact with x-rays exposed to; replace monthly; provide reports	Ability to provide for all FCM facilities Competitive pricing Timeliness of replacements and reports * Required documents–b, f

Radiography interpretation	Regular interpretation of films and written reports, including stat as required; courier as needed	Timeliness of all services Qualifications of providers Ability to provide statewide if possible * Required documents–a, b, c, e, f, g, h
Radiology	May be more than one type of service to include mobile for on-site services or off-site for complex radiography that cannot be completed on-site	Proper certifications Quality and timeliness of service Ability to provide myriad of services Ability to provide statewide if possible * Required documents–a, b, c, e, f, g,
Service agreements	Variety of agreements for repair or maintenance of equipment such as x-ray machines and other medical equipment, office equipment, information systems,	Ability to provide services statewide Competitive pricing Emergency services available Proper licensing Quality of work * Required documents–b, h

* Required documents:

a. Written verification of education and experience
b. Verification of current license and/or DEA certificate
c. Investigation for adverse action on license and/or hospital privileges
d. Verification of letters of recommendation
e. On-site inspection of medical providers' offices
f. Personal interviews
g. Verification of malpractice history and appropriate state and federal agencies
h. Regular re-certification of participating medical providers (may be delegated)

2. Retention

In general, FCM prefers to contract for all providers within a medical group or medical provider association. However, under some circumstances, FCM does drop particular providers in such groups. Reasons include some members' not wanting to participate, individuals who do not meet the specifications of FCM, and the request of specific providers not to be included.

J. Implementation Plan

1. Transition (start-up)

FCM has successfully started or transitioned services for twelve contracts during the last three years. For existing services, some transitions have been trouble-free and characterized by cooperation. Others have been characterized by hostility and complete lack of cooperation by the vendor being replaced. Regardless, FCM has remained collaborative and determined to ensure a smooth and secure transition. As an example of an adverse transition, when FCM was awarded one particular contract, the existing contractor's management team gathered together health services staff and told them they were all fired then left the room. Such behavior is counterproductive for everyone involved. To avoid this, FCM commits to a smooth, cooperative transition from start-up through transition to the next vendor.

The first step in a successful transition is to determine the expectations of the Department of Correction. To do this, immediately upon contract award, FCM will assemble its transition team. As discussed in the staffing section above, this team will be dedicated exclusively to working in Delaware and will remain there for at least the first six months.

As soon as allowed by the Department of Correction, staff will set a series of meetings with the Department of Correction and the current vendor to discuss all activities that will occur during the pre start-up period (from contract award through the first day of services). From the initial meeting FCM will develop its comprehensive plan that will encompass the pre start-up period and the first six months of operation. Successful transition will not be difficult for FCM as the company has successfully started or transitioned services for ten contracts during the last several years. Never has FCM failed to meet commitments and contract requirements.

- Recruitment of current and new staff

FCM will encourage existing health services staff to apply for positions in the health services units. FCM will offer inducements such as providing excellent benefits and providing comparable salaries as much as possible. FCM believes strongly that hiring existing staff is superior to recruiting and training new staff. Existing staff already understand the challenges of working in correctional settings, have been oriented and trained for their positions, and are presumably trained for their positions. Of course, FCM will expect all staff in the medical units to meet the qualifications of their positions and abide by FCM's policies, procedures, and other requirements of FCM. All retained employees will also be subject to FCM's initial 120 day probation period.

During the transition period, the director of operations, the human resources manager, the nursing educator, and the director of development, in cooperation with on-site staff, will recruit, hire, and train all staff needed. Immediately upon notification of the recommendation of contract award, staff will begin recruitment for key positions. Corporate staff members will be instrumental in staffing and other human resources functions throughout the transition period as well as during ongoing operations.

- Subcontractors and specialist

As soon as possible after FCM receives notification of contract award, staff will request a meeting with the Department of Correction and the existing health services vendor. The purpose of the meeting will be to discuss the requirements of the Department of Correction and to obtain comprehensive information about existing contracts, subcontractors, and relationships.

FCM intends to maintain relationships with existing subcontractors, at least initially, to ensure a seamless transition period between operation by the current vendor FCM. However, if FCM can identify substantial savings of some facet of operations without compromising quality of service and dependability, FCM will encourage present subcontractors to be included in any bid process. After the transition period, FCM will conduct a review at least every twelve months to ensure that all activities are as cost effective as possible.

The director of development will be responsible for coordinating with staff of the Department of Correction, medical contractors, and other subcontractors throughout the transitional and start-up periods. Responsibilities will also include organizing activities between FCM's corporate and on-site staff as well as developing the overall model for delivering services at the Delaware facilities.

- Hospital services, including off-site secure unit

As discussed above, FCM will have a fully dedicated transition team on-site in Delaware for at least the first six months. One of the key components is securing contracts, especially for hospital services. To secure such contracts, FCM will meet first with the contracting specialists of the hospitals that currently provide services at the existing facilities. If possible, FCM will obtain contracts of the existing health services vendor for hospital services or at least obtain information regarding the services provided. The purpose of the meetings will be to ascertain each hospital's interest in continuing to provide correctional services and the level of services available.

FCM staff will also research other hospitals that are available and will contact appropriate staff to set appointments to discuss services available and possible contracting.

To the extent possible, FCM contracts for comprehensive services through its contracted hospitals. Staff will identify the hospitals that offer the most comprehensive services and target them for intense negotiations. Such services include inpatient and outpatient, clinics (off-site and on-site), laboratory, x-ray, emergency pharmacy (if not provided by the pharmacy contractor of the Department of Correction), secure inpatient and outpatient areas, etc.

FCM is aware that some hospitals traditionally do not care to provide correctional health care services. FCM will concentrate its discussions with the traditional and safety net hospitals who are more likely to treat this population.

- Pharmaceutical, laboratory, radiology, dental, and medical supplies

FCM will seek assistance from the Department of Correction in arranging services with the pharmaceutical provider. Staff is aware that there are several means of distribution currently used

in the facilities. As soon as possible, FCM plans to institute the bar code tracking discussed above. Early collaboration with the pharmacy vendor is imperative. Some of the other key components that must be discussed are:

- Delivery schedule (days and times)
- Providing stat medications
- Packaging for all types of delivery
- Ordering
- Patient profiling
- Inventory control and par levels
- Procedures for controlled substances
- Licensing and other regulations
- Accounting
- Pharmacists' services

- Identification and assuming current medical care cases

Plans for transferring the medical care of current inmates to FCM will begin immediately upon contract award. FCM will request a meeting with the Department of Correction and the three regional managers of the existing vendor. The purpose of the meeting will be to set a plan for providing FCM medical staff all information regarding inmates receiving services at the start-up date of the contract. This will include inmates in chronic care clinics; on-site infirmaries; and off-site facilities including hospitals, dialysis patients, and special needs inmates. FCM will also seek assistance in ensuring that financial responsibility is transferred appropriately. One key component of the overall plan will be the identification of the correct staff members from FCM and the current vendor to meet in each facility to individually review the care, record, status, and treatment plan for each identified inmate.

- Equipment and inventory

FCM expects that all equipment and inventory will remain as it was the dates of the site visits. Although the Department of Correction provided an inventory list, it was not until after the site visits. Thus, staff could not compare the list to the existing equipment. FCM recommends a detailed inventory of all equipment. The inventory would be undertaken jointly with FCM staff and the current vendor as well as representatives from the Department of Correction. In the equipment and supplies section of the proposal, FCM discussed purchasing of equipment. FCM recommends that FCM purchase and maintain ownership of any items costing under $500 and that the Department of Correction purchases and maintains ownership of any items over $500. Fixed items (such as dental chairs) would be the sole responsibility of the Department of Correction to purchase and maintain.

FCM staff will not only conduct an initial inventory of all equipment but will also maintain an ongoing inventory of the equipment. The inventory will track any equipment that is added, damaged, becomes obsolete, is replaced, etc. This inventory information will be readily available for Department of Correction staff to review.

- Medical record management

FCM has extensive experience in developing medical records administration plans and an in-depth policy for medical records. Its cornerstone is the maintenance of confidential medical records for all inmates that are accurate and contain chronological documentation of inpatient and outpatient medical, dental, and psychological care rendered. Medical records requirements comply with all state and federal statutes and national medical and correctional standards. Mental health records are discussed in the mental health section of this proposal.

FCM will conduct a thorough analysis of the current medical record system in each facility and within thirty days of start-up have a comprehensive plan and timeline either to overhaul the system if it does not meet FCM's standards or at least complete a comprehensive inventory and examination of the existing records. FCM's medical records administration is consistent, reliable, and in compliance with NCCHC standards. It includes:

- Maintenance of records. Inmate medical records will be maintained in the health care unit. The health services administrator will oversee the operations of this area.
- Format. A problem-oriented medical record format will be used. FCM has designed and implemented an effective medical record system that is in compliance with NCCHC standards. It is important that each medical record is complete, filed promptly, and most importantly, contains accurate, legible entries.
- Audits. Medical record audits for completeness will be undertaken at least quarterly, under the supervision of the health services administrator. Records will be reviewed for compliance and recommendations for corrective action will be made.
- Confidentiality of information. The information acquired in a health professional-patient relationship will be considered confidential. The active medical record will be maintained separately from the individual's confinement record.
- Informed consent. Informed consent standards will apply to all examinations, treatments, and procedures with the exception of emergency situations and the treatment of communicable diseases.
- Loss of records. Strict procedures will be established to prevent the loss of medical records. A tracking mechanism and immediate filing of all records in a secure area following treatment will be implemented.
- Inactive records will be maintained in accordance with Delaware law as well as NCCHC standards and will remain the property of the Department of Correction.

- Orientation of new staff

The staff orientation section details FCM's orientation program. Briefly, FCM has prepared two orientation programs. One will be for existing staff who have been fully trained in correctional health care. Their orientation will center on policies, procedures, and processes of FCM. This orientation will satisfy the training standards required by NCCHC.

New staff will receive all training required by NCCHC. In addition, each employee will be required to complete a forty hour preceptorship and a monitored orientation before assuming a shift.

assignment. At any time during the medical orientation, the health services administrator and the preceptor in collaboration may determine the need to extend the required orientation hours.

Because medical and correctional personnel are in frequent and close contact with inmates, they will receive special training from the mental health staff in the identification of individuals with possible emotional, mental, and developmental disorders.

Timetables

The following table is a preliminary start-up plan that covers the time period from contract award notification through assumption of services. This tool is intended to serve as a part of the company's overall strategic plan, and as thus is a beginning point. Undoubtedly, during contract negotiations and as a result of obtaining new information, items will be modified. Certainly, many items will be added. All key members identified in the transition plan will develop their specific goals, objectives, assignments, and timelines within this broad framework. For instance, the office manager at the corporate office will be responsible for finalizing arrangements by July 1 for malpractice insurance, biohazardous waste, and medical soft goods. Before this date, the office manager will assign specific tasks to individuals to complete in order to meet the July 1 deadline.

The key contact for the transition period will be the director of development with the transition team identified above. The team members' résumés are included as attachment 15. Of course, the chief executive officer and director of operations will work closely with both the transition team and others in the Department of Correction, the community, and the facilities.

The chart indicates scheduled completion dates for tasks and deliverables and also identifies the time frame for integrating current health care services employees and subcontractors. These topics are also addressed in the narrative section above.

FCM has a master policies and procedures manual as well as a comprehensive infectious disease manual, both described in detail above. The director of clinical services is responsible for updating and editing these documents as well as customizing them for each facility that FCM operates. For instance, this director recently completed customized master documents to meet the requirements for FCM's most recent facility located in Ontario, Canada. She researched Canadian and Ontario law, changed the documents accordingly, and provided them to the chief executive officer for approval. Then, the nursing educator incorporated them into ongoing educational training for facility staff and corporate staff ensured that the manuals were distributed appropriately. FCM will follow a very similar procedure for customizing the documents for Delaware. As outlined in the table below, the director of clinical services will complete a first draft of the revised documents by June 17 and a final, approved set by the week of July 15.

Table 10 below is broken into three sections: general recommendations to the Department of Correction, the FCM staff with overall responsibility for a group of tasks during the start-up period, and week-by-week accomplishments. Each week's list will also include key accomplishments for the week and specific deliverables to the Department of Correction that week.

Table 10. Preliminary transition plan indicating timetables and personnel

General recommendations to Department of Correction Staff
1. Start-up services September 1, 2002, to allow time for well-planned, smooth transfer
2. Prior to start-up, request that current vendor provide to FCM all relevant information about existing staff and coordinate interview times for staff interested in applying
3. Provide immediate access to the contracts of existing subcontractors and copies of contracts
4. Provide a letter of introduction and explanation to the existing subcontractors
5. Complete as soon as possible background checks of FCM staff
6. Allow staff to meet immediately with each facility's warden or designee to start planning transfer
7. Provide access as soon as possible to FCM to inmate medical files to facilitate preparing comprehensive medical file transfer plan

General Area of Responsibility	Person
– Hiring new and existing staff and ensuring that all human resource information is in order	Human resources manager
– Orient all staff as needed and provide continuing education	Nursing educator and human resources manager
– Establish contracts with new and existing subcontractors	Director of development
– Coordinate all on-site services	Director of operations
– Prepare for NCCHC re-accreditation	Director of clinical services
– Update policies and procedures for Department of Correction	Director of clinical services
– Plan and execute training of health care and corrections staff	Nursing educator
– Set up books and accounts for Delaware	Finance staff
– Work with each health department regarding communicable disease reporting, services available, coordination, etc.	Director of clinical services
– Set up specific business functions	Corporate office manager
– Obtain insurance additions (workers' compensation, liability, malpractice)	Corporate office manager
– Establish all procedures for pharmacy	Director of clinical services
– In conjunction with Department of Correction staff, conduct inventory of all equipment	Direction of operations
– Develop medical records administration plan	Director of operations
– Coordinate with Department of Correction regarding information systems plan	Director of operations

June 3 – 16

Key accomplishments: initiate all staff activities for pre-transition services; draft contract between FCM and Department of Correction Specific deliverables to Department of Correction: all materials for background clearances of transition team and executive staff	
– Complete all components of transition plan	Director of development
– Complete job descriptions – Secure information for corporate staff clearances and submit material for transition team clearances	Human resources manager
– Coordinate logistics for transition team to go to Delaware	Office manager and corporate staff
– Contact real estate service for obtaining office space	Office manager and corporate staff
– Begin work on plan to transfer services to next vendor (set meeting with Department of Correction and others as appropriate)	Director of development
– Coordinate with FCM attorney regarding contract	Chief executive officer
– Analyze existing staffing and determine needs – Determine specifics regarding personnel transfers (such as vacation, benefits, salaries) – Finalize recruitment plan to include specific plan for positions potentially difficult to fill such as dentists and pharmacist – Advertise for staff – Set up Delaware database for tracking employees' documents – Set meeting with representatives of nurses' union	Human resources manager
– Set up new employees' files – Obtain information about benefits for new employees	Human resources manager
– Set appointments for office site visits	Office manager and corporate staff
– Meet as early as possible with contracted pharmacy vendor – Begin development of disaster plan in conjunction with the Department of Correction	Chief executive officer and director of clinical services

June 17 – June 30

Key accomplishments: transition team in Delaware; subcontractors' negotiations begin Specific deliverables to Department of Correction: final contract executed, draft policies and procedures manual; staff recruitment and training schedule	
– Complete contract negotiations and sign – Continue to discuss transition with Department of Correction staff	Chief executive officer
– Initiate contract discussions with current and new subcontractors	Director of development

– Begin discussions with FCM's current subcontractors (lab, eyeglasses, medical supplies, etc.) to extend services to Delaware	Office manager and corporate staff
– In-depth tour of all facilities – Meet with detention staff management at each facility	Director of operations
– Establish plan for revamping mental health services – Set meetings with existing mental health services providers, if appropriate	Director of mental health services
– Work with Department of Correction and current vendor's staff for conversion of existing staff who want to apply to work for FCM – Complete staff recruitment and training schedule	Human resources manager
– Post new positions internally – Place ads, etc. – Set appointments and begin interviews of existing staff – Ensure documents in order for all existing staff – Secure site for interviews (local hotel, Kinko's, FCM Delaware office when available)	Human resources manager
– Obtain list of current subcontractors	Director of development
– Establish timeline for preparing for NCCHC re-accreditation	Director of clinical services
– First draft completed to revise policies and procedures specific to Department of Correction	Director of clinical services
– Develop written work plan to cover first twenty-four months	Director of development
– Transition team in Delaware	Office manager and corporate staff
– Establish meeting schedule with key participants (Department of Correction, wardens, current vendor, key subcontractors, etc.) – Select office location (temporary if necessary while permanent site in progress)	Director of development
– Meet with current vendor and staff of Department of Correction to establish plan for orderly transfer of medical records and care of existing inmates with medical conditions – Establish plan for financial considerations for inmates in treatment	Director of operations, chief executive officer
– Set meeting dates for each warden to meet with chief executive officer and director of operations	Director of development

July 1 - 15

Key accomplishments: high level planning meetings begin; MIS and human resources components moving forward Specific deliverables to Department of Correction: items required thirty days after contract award: formulary; information concerning proposed subcontractors; list of employees and subcontractors who require licensing or certification and report stating that all employees and subcontractors are licensed or certified as required (report to Deputy Bureau Chief of Management Services)	
– Meet with key participants (Department of Correction, wardens, current vendor, key subcontractors, etc.)	Chief executive officer, director of operations
– Establish staff training schedule	Human resources manager, director of clinical services
– Begin setting up financial system for Delaware facilities	Finance staff
– Continue interviews of existing staff – Screen résumés and applications – Begin preliminary interviews for new applicants	Human resources manager
– Gather information for employee packets – Work with insurance broker to establish benefits for Delaware staff	Office manager and corporate staff
– Contact existing subcontractors – Determine needed new subcontractors – Schedule appointment with appropriate public health staff to discuss services they can provide	Director of development
– Review medical records system; revise as needed with assistance of corporate staff – Coordinate work between FCM's MIS staff and appropriate Department of Correction staff for inmate tracking capability – Continue ongoing meetings with corrections staff, kitchen staff, etc.	Director of operations
– Begin development of written medical records administration plan – Prepare written quality assurance plan	Director of clinical services
– Request meeting with Medical Review Committee, if appropriate, to discuss issues and future meetings – Meeting of information system staff between Department of Correction and FCM	Chief executive officer and director of operations

July 15 - 29

Major accomplishments: establishment of many on-site and off-site services; mental health services plan completed Specific deliverables to Department of Correction: comprehensive equipment list; status report of negotiations for subcontractors; required package of résumés and letters of intent for key positions in each facility

– Continue meetings with key participants (Department of Correction, wardens, current vendor, key subcontractors, etc.) – Meet with key staff of current vendor such as medical director, mental health director, dentists	Chief executive officer, director of operations
– Determine equipment needs (including emergency equipment) – Work with transition team to order equipment	Finance staff
– Order needed supplies for medical records – Order first aid kit materials	Office manager and corporate staff
– Finalize résumés and letters of intent for key positions	Human resources manager
– Customize detailed officer training – Determine training needs of current staff (corrections and medical contractors)	Human resources manager, nursing educator
– Establish detoxification programs as needed	Director of clinical services
– Complete plans for revised mental health services in all facilities	Director of mental health services
– Work on specific contracts after reviewing current vendor's contracts – Prepare instructions to subcontractors describing process for billing and payments – Ensure that billing system in place at corporate office	Office manager and corporate staff
Finalize arrangements for: – Answering service – Malpractice insurance – Medical soft goods	Office manager and corporate staff
Finalize arrangements for: – Consultants and radiologist – Eye glasses – Oxygen	Office manager and corporate staff

July 30 – August 12

Major accomplishments: Key staff hired Specific deliverables to Department of Correction: list of selected key staff for background clearance	
– Hire selected health services administrators and other key staff	Human resources manager, director of operations
– Evaluate current medication distribution plan in all facilities	Director of clinical services
– Work on details of NCCHC preparations – Refine infection control plan	Director of clinical services
– Meet with substance abuse contractor to plan coordination of services	Director of mental health services

Finalize arrangements for: – Biohazard waste – Lab contract	Office manager and corporate staff
Finalize arrangements for: – Dental lab – Pager and cell phones medical providers, mental health staff, nursing supervisors – Ambulance and other EMS services	Office manager and corporate staff
– Coordinate with Department of Correction information system for routine and ad hoc reports – Ensure that inmate tracking system is in place – Evaluate existing medical request system and plan revisions	Director of operations
– Finalize orientation program for existing staff – Finalize quality assurance program	Director of clinical services
– Establish initial health assessment and booking procedures – Set up chronic care clinic system – Establish guidelines for transports off-site – Analyze pharmacy and dispensary system – Inventory pharmacy supplies	Health services administrator, Director of operations
– Meet with each facility's Medical Administrative Committee at appropriate time for each facility	Director of operations and health services administrator of each facility

August 13 – August 26

Major accomplishments: Job offers extended; policies and procedures completed; key on-site staff begin working; many on-site services ready for implementation Specific deliverables to Department of Correction: complete policies and procedures manual and supporting documents, list of all certificates including any out of date; work plan for first twenty-four months, medical records administration plan, copies of all forms used at the facilities	
– Continue making employment offers	Human resources manager, director of operations
– Ensure that legally required human resources information is posted at every site	Human resources manager
– Put together employee packets	Human resources manager
– Order and set up reference materials per proposal (medical, subscriptions, policies, procedures) – With corporate staff, customize forms and inmate materials (segregation flow sheet, consult request form, physician extender appointment log, kitchen clearance form, clinic referral form, refrigerator log, oxygen log, isolation check log, diet log, emergency department log, etc.) – Set up system for reports and committee meetings	Director of clinical services

– Coordinate with Department of Correction information system for routine and ad hoc reports – Ensure that inmate tracking system is in place – Evaluate existing medical request system and plan revisions	Director of operations
– Submit complete revision of policies and procedures, approved by chief executive officer, to Department of Correction	Director of clinical services
– Review all certifications and plan for renewal as needed	Director of development
– Health services administrator and other key staff to start	Human resources manager
– Finalize orientation program for existing staff – Finalize quality assurance program	Director of clinical services
– Establish initial health assessment and booking procedures – Set up chronic care clinic system – Establish guidelines for transports off-site – Analyze pharmacy and dispensary system – Inventory pharmacy supplies	Health services administrator, Director of operations
– Complete written work plan covering first twenty-four months	Director of development, Director of operations
– Complete and submit written medical records administration plan	Director of operations, Director of clinical services
– Meet with Department of Correction to discuss an implementation plan for the telemedicine system	Director of development
– Meet with each facility's Medical Administrative Committee at appropriate time for each facility	Director of operations and health services administrator of each facility
– Ensure that all forms are revised, printed, and ready for distribution in each facility	Director of clinical services and corporate staff

August 26 to September 8

Key accomplishments: Start-up September 1; all positions filled; all services in place Specific deliverables to Department of Correction: presentation of detailed medication distribution plan for each facility, pharmacy procedures; detailed plan for transfer of services to next vendor; draft of disaster plan	
– Other key staff to begin	Human resources manager
– Staff orientation for key staff	Human resources manager
– Medication distribution plan ready for each facility (pill call, medication boxes, keep on person, commissary, etc.)	Director of clinical services and health services administrators
– Train corrections staff as needed	Director of clinical services
– Complete negotiations for on-site and off-site contractors	Director of development

– Ensure all components of medical request (kite) system in place – Finalize revamping pharmacy system	Health services administrators
– FCM staff present at all shift change meetings in every facility to discuss transition of services	Health services administrators and transition team
– All positions filled – Training and orientation continues as needed	Human resources manager
– Meet with all functional areas of each facility such as food services, transportation, and security	Each health services administrator and director of operations
– Ensure that all certificates are up-to-date in each facility – Submit draft disaster plan to Deputy Chief of Management Services and each warden for comments (final by September 4)	Director of clinical services
– Completion and delivery to Department of Correction the detailed plan for transfer of services to next vendor	Director of development

Potential problems and solutions anticipated during start-up

FCM anticipates no insurmountable problems during the transition period. Staff of the current vendor, like FCM, are professional and will undoubtedly work cooperatively for a smooth transition. That does not mean that there will not be challenges. During the facility tours, FCM became aware of some issues but certainly others will emerge. Two strategies are essential in success under these circumstances: 1. comprehensive planning to identify problems and solutions and 2. willingness to work cooperatively with all involved. FCM is very experienced with transitions and start-up activities. Some of the obstacles that may occur, along with their solutions are summarized below. By no means is this meant to be a comprehensive list but a beginning point.

Table 11. Potential problems during transition and solutions

Potential problem	Solution
Difficulty recruiting dentists	– Involve FCM's dental consultant – Active recruitment plan from the day of contract award – Make personal contacts with current providers and other potential providers in the area
Existing staff anxiety	– Meet as early as allowed to discuss any concerns in groups and individually – Provide good benefit package and salary – Request collaboration of current vendor during transition – Arrange early meeting with union representatives
Time lag obtaining security clearances for FCM staff	– Set meeting with appropriate staff as soon as possible – Human resources manager personally oversee submission of all required documents

Finding suitable office space	– Immediately seek assistance from real estate service – Willing to set up temporary office – Transfer one or more corporate office staff to the Delaware corporate office
Resistance for exiting vendor and difficulties with medical records, consultations, filing, pharmacy, chronic care, etc.	– Hire as many existing staff as possible – Early and ongoing discussions to include current vendor, Department of Correction and FCM

2. On-going

General approach to managing the project

FCM's approach for managing its contracts is direct, personal management of all aspects. FCM has selected to remain a small company and grow slowly. One of the reasons for doing so is that the chief executive officer and her executive staff want to maintain this level of personal involvement. This philosophy continues at the level of the individual facilities. The director of operations, and particularly each health services administrator meets frequently and regularly with staff of each facility. Although formal meetings with agendas and minutes are essential in a health care setting, perhaps more important are the informal meetings between staff who work together. A discussion with FCM's current contracting entities will confirm also that FCM's executive and corporate staff are always responsive and follow-up with all requests and requirements.

Besides ensuring smooth administrative aspects, FCM's chief executive officer is adamant about providing quality health services that meet standards of not only the NCCHC but also ACA, JCAHO, and guidelines such as those of the CDC. Remaining small allows the chief executive officer, a medical doctor, to ensure that every facility indeed meets this directive. FCM may not offer the lowest price because staff know that providing quality care requires hiring quality staff and meeting required staffing mandates.

FCM will establish a corporate office in the Dover area. Staff there will coordinate regularly with the corporate staff in Tucson, Arizona. Some of the key responsibilities of the Delaware corporate office staff will be to support the staff in each facility. This will include ensuring that communication remains efficient with the Department of Correction in areas such as submission of reports, establishing meetings and preparing agendas and minutes, etc.

Chart showing staff hours

FCM has included several documents that address specific staffing numbers and patterns. Section H. above includes detailed staffing plans that include staffing levels, numbers, and times by position (days, evenings, nights, weekends). The patterns also indicate the full-time equivalents (FTEs) and system-wide management staff needed to manage all facilities. Table 12 below correlates the tasks required in the request for proposals to particular staff.

Problems and solutions anticipated during course of contract

The list of potential problems during the course of the contract is virtually endless. Problems will occur. Some will be anticipated; others will emerge. They could range from a minor personnel problem in one facility to a major disaster throughout all facilities. The only way to manage such problems is by preparing. Key factors in preparedness are well trained staff, comprehensive policies and procedures, ongoing communications and interagency training, continual recruitment, aggressive management of problems as they occur, regular meetings with established committees such as the Medical Administrative Committee and the Medical Review Committee, and ongoing strategic planning by FCM's executive staff. These are not idle catch phrases but the very real way that FCM accomplishes its business. Success in identifying and handling problems can be verified by contacting any of the references included in this proposal.

3. Transfer of services to next vendor

FCM is professional and ethical. There will be no problems such as disagreements over equipment ownership, staff's ability to remain with the new vendor, etc. However, being professional and ethical will not accomplish the details of an orderly transfer. Therefore, during FCM's start-up period, staff will prepare a detailed plan for an orderly transfer and deliver this to the Department of Correction by the start-up of services.

Table 12. Staffing positions correlated with tasks of request for proposals

Labor Category	Tasks and Subtasks
Certified nursing assistant (CNA)	Assists with provider lines for mid-level providers and physician including vital signs, photocopying, visual acuity checks for physical exams and referrals Restocks and cleans exam rooms Restocks supply room Assists in response to medical emergencies Assists in medical records as needed
CID nurse	Oversees OSHA infection control program Maintains PPD log, enforces compliance with tuberculosis prophylaxis program Assists with employee new and annual PPD testing and hepatitis B program Sees all inmates on INH for monthly visit Ensures monthly reporting to state and county health departments Coordinates the HIV on-site clinic with the medical director Keeps the National Institute of Health, Centers for Disease Control and Prevention, and state health department inmate education material current and available
Dental assistant	Records patient health history and vital signs and provides education Performs radiography and dental laboratory techniques Provides assistance in preventive, periodontal, restorative, endodontic, prosthodontic, and oral surgery procedures

	Performs sterilization and disinfection of instruments and equipment Observes infection control procedures for the safety of the patients and staff
Dentist	Provides dental services for inmate population including periodontic, restorative, endodontic, minor oral surgical and exodontic, and prosthodontic services Provides guidance and technical supervision to dental assistants Coordinates dental clinic operations with the health services administrator Performs documentation in dental health records Coordinates and participates in patient education programs and services Works with interdisciplinary medical team to optimize dental health
Dietitian	Establishes menus that address medical needs while maintaining cost control Monitors and makes recommendations for dietary needs of diabetic, chronically ill, pregnant and oral surgery patients Coordinates with food service unit on medical dietary needs Provides inmate education on dietary needs, consumption and commissary use Practices in accordance with *Manual of Clinical Dietetics* and *Manual of the American Dietetic Association*
Director of clinical services (as needed)	Responsible for establishing all medical unit clinical operations In conjunction with nurse educator designs nursing in-service programs, including AED training Assures compliance with FCM policies and procedures and applicable state pharmacy regulations Revises policies and procedures as necessary to meet requirements of Department of Correction Responsible for all components of NCCHC re-accreditation
Director of operations (as needed)	Has final authority, accountability, and responsibility for all medical unit operations including staff assignments, distribution of staff during normal and abnormal operations scenarios Locates and maintains outside contracts for specialty care, hospitals, EMS providers, and related tasks Designs all logs and computer utilization Serves as liaison for FCM during client audits
Health services administrator–RN	Oversees all functions of the medical unit Oversees grievance procedures Responsible for all staffing functions including counseling Establishes standard operating procedures Manages ACA and NCCHC accreditation functions, completes ACA and NCCHC files, and institutes ACA and NCCHC procedures Prepares work schedules Maintains documentation for records, department meetings, and in-service sessions Oversees operations and budget reports to corporate office Leads nursing in-service training classes

	Supervises new employee orientation Oversees court chart chronologies
Licensed practical nurse (LPN) – central medical staff	Ensures over-the-counter and medical soft goods par levels Performs nursing functions as needed during clinics and emergencies Assists with provider lines and segregation rounds each shift Picks up sick call requests Reads all PPD tests Draws all ordered and mandatory labs for institution Performs all EKGs Maintains the lab log book, noting all provider orders Answers main nursing station phone Updates blood pressure and treatment logs Maintains and forwards diet logs Starts medication administration records based on the new orders Maintains EKG log Performs all treatments as ordered by providers
Licensed practical nurse (LPN) - intake	Provides immediate pre-booking screening Calls in or writes referrals to medical and mental health staff as indicated Completes appropriate portions of intake paperwork Performs PPD administration if inmate known to be at jail forty-eight or more hours Performs initial screening Provides detox referrals
Management information systems (MIS) manager	Determines computing needs and system requirements Implements and monitors backup and disaster recovery functions Maintains resources necessary to troubleshoot and mitigate problems Trains personnel on application and network operations and resources Designs, develops and maintains databases Ensures confidentiality and security of data Administers security to restrict unauthorized use Manages authentication, encryption and audit Oversees telecommunications systems Oversees internet web site
Medical records clerk	Creates new charts Conducts all medical chart loose filing Prepares daily lay-in lists Retrieves, stores, and transfers medical records Archives medical records as appropriate Prepares mail files Maintains provider schedules and medical appointments Generates passes for medical services Collects and maintains data for medical records portion of statistics Double-checks charts to ensure that orders are noted, timed, etc. Maintains chart security Enters encounter form data Schedules and updates chronic care clinic

	Logs, verifies, copies, and distributes all outside medical service invoices for the medical service unit Carries out medical records movement functions as unit clerk and takes off orders with second note by RN
Mental health clinician	Develops and implements therapeutic programs for assigned inmates Assumes independent clinical responsibility for application of crisis intervention techniques including suicide prevention, recognizing abnormal behavior and taking appropriate action to prevent or diffuse potentially disruptive situations Conducts tests to determine needs, establish goals and develop plans Makes referrals for assessment and treatment Prepares progress reports and discharge plans
Mid-level provider	Performs physical exams (including all incoming female pap and pelvic exams) Sees any urgent intake inmates, especially on weekends Reviews, initials, and document treatment plans for all lab, X-ray, and consult reports Assesses medical isolation inmates on weekends and document a progress note Provides primary care for sick call referrals, walk-ins, urgent care visits, and overflow routine physical exams including annual exams Ensures that all in-house provider clinics function smoothly Attends and organizes monthly provider meeting for mortality review, case management, and grand round style lectures Provides weekly correspondence with corporate medical team
Nurse educator (as needed)	Responsible for medical staff education Responsible for correctional staff education In conjunction with director of clinical services, designs nursing in-service programs, including AED training Designs and implements inmate orientation and inmate education for acute and chronic illnesses
Pharmacist	Compounds, dispenses and preserves drugs; makes substitutions as appropriate Manufactures pharmaceutical preparations and fills orders to supply facilities Prepares solutions and sterile vehicles necessary to correctional settings Responds to inquiries on drug contents, dosages, regimen review, errors, storage and disposal Monitors drug therapies for drug interactions, allergies and contraindications Supervises monitoring of inventory and procurement drugs and supplies Conducts in-service training for healthcare workers Provides assistance to interdisciplinary medical in correctional settings Maintains records and prepares reports necessary for corporate, state, federal, ACA and NCCHC purposes, including narcotics

Pharmacy technician	Controls all ordering of over-the-counter and legend medications Stocks all pill carts Verifies all received medications with orders Delivers medication administration record and medications as needed
Physician – medical director	Provides on-site medical services for inmates in chronic care clinic or those referred from mid-level providers, nurses, mental health team Handles call twenty-four hours a day Directly assesses and treats all emergency patients–inmates, employees, or visitors Assesses and monitors directly any inmate on detoxification protocol Immediately assesses any critically ill intake patient or new intake with sign Sees inmates with chronic conditions within seventy-two hours of arrival Serves as supervisor of mid-level providers Oversees morbidity and mortality review Serves as active member of the QA committee Facilitates monthly joint staff meetings between mental health and medical staff Performs peer chart reviews monthly Facilitates outside consultant services to ensure excellent care Performs daily monitoring and reporting of all outside hospital and emergency visits
Psychiatric registered nurse (RN)	Participates in development of treatment plans Administers and monitors medications Responds to medical and psychotropic medication emergencies Provides crisis management for disturbed patients Supervises use of restraints and seclusion Assists psychiatrist in examinations and treatment of patients Applies nursing techniques with goal of stabilizing inmate function in the institution and community
Psychiatrist	Conducts assigned multidisciplinary psychiatric treatment team(s) Monitors clinical status, therapeutic progress, medication benefits Develops and reviews all initial treatment plans and reviews Develops discharge treatment plans and summaries Writes medication orders in accordance with FCM policies Makes entries into the psychiatric inpatient records Develops comprehensive psychiatric evaluation for each client Determines need for enforced medication Reviews randomly selected psychiatric records for quality of care
Psychologist	Develops and implements treatment and therapeutic programs for inmates Assumes independent clinical responsibility for inmates, applying crisis intervention techniques to include suicide prevention Recognizes abnormal behavior and takes appropriate action Conducts tests for inmates to determine needs, establishes goals and

	plans Makes referrals for assessment and treatment of inmates Provides individual and group counseling to inmates Prepares progress reports Provides recommendations regarding discharge plans Makes case presentations Assists in development of statistical reports on assigned inmates Recruits, trains, and supervises performance of mental health personnel Makes recommendations on personnel actions
Quality assurance nurse – RN	Develops facility specific quality assurance (QA) program Implements continuous quality improvement (CQI) program and management reports and directs quarterly CQI meetings Completes facility monthly audits Compiles all unit monthly statistic Maintains QA computer data Assists in ACA and NCCHC tasks Handles all incident reports including trending Investigates all medication errors Maintains and correlates the Psychiatric Medication Monitor from psychiatric nurse for the FCM weekly report Implements all corrective action plans formulated from the QA report including appropriate nursing education
Registered nurse (RN) – central medical staff	Conducts rounds for observation unit Maintains charting, medications, treatments, admissions, and discharges Performs pre-segregation physicals, pre-employment drug screens, and physical exams when supervisor is unavailable Administers treatments including insulin and provider-ordered injections Takes and transcribes orders Provides services during emergencies inside and outside the medical unit Performs employee PPDs for medical and correctional staff Performs segregation rounds Reviews all inmates returning from outside appointments Serves as second note to all provider orders; makes medication administration record
Registered nurse (RN) - intake	Provides immediate pre-booking screening followed by full medical intake after cleared by custody Calls in or writes referrals to medical and mental health staff as indicated Completes all intake paperwork Performs PPD administration if inmate known to be at jail forty-eight or more hours Performs screening including pregnancy testing on female inmates Provides detox referrals
RN supervisor (nursing supervisor)	Works as charge nurse on floor with specific attention to staff functions and organization Manages work schedules Provides daily monitoring of all log books and oversight of nurse sick call

	Assists with RN functions as needed for provider line Responds to grievances Assists with inmate and staff emergencies or exposures Counsels employees Ensures completion of quality assurance functions Oversees infectious disease areas Provides pre-employment urine toxicology collection and physical exams Provides coverage for floor RN when needed; serves as backup nurse for intake staff
System coordinator	Performs on-site personnel management including payroll Oversees purchasing, supplies, inventory control, repairs, maintenance, computers and systems, management reports; Maintains all FCM computer logs Provides support as a co-facilitator with the HAS for HSA. duties listed above Supervises medical records section Prepares minutes for meetings (special needs, CQI, staff, etc.) Reports directly to FCM corporate office to Director of Operations
X-ray technician (radiologic technician)	Performs all routine radiographs Maintains all films on file Updates X-ray log Transports the films to radiologist for interpretation Orders all processor supplies, Assists HSA in obtaining and maintaining equipment certificates

Proposed Pricing

The cost summary proposal and proposed pricing documents, along with supporting documents, are included in a separate sealed envelope labeled "proposed pricing."